Serie de Estudios ISALUD

Serie de Estudios Nº 7 - 2008

Clasificaciones Diagnósticas en Psiquiatría: Apectos clave para su uso en Salud Pública.

Dr. Hugo Barrionuevo, Dr. Dante Graña.

ISBN: 978-987-9413-46-3

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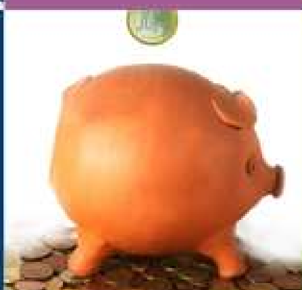

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Departamento de Investigación

Barrionuevo, Hugo

Clasificaciones diagnósticas en psiquiatría: aspectos clave para su uso en salud pública

Hugo Barrionuevo y Dante Graña.

1a ed. - Buenos Aires: ISALUD, 2008.

Internet. - (Serie de Estudios ISALUD; 7)

ISBN 978-987-9413-46-3

1. Salud Mental. 2. Psiquiatría. I. Graña, Dante II. Título

CDD 616.89

Hecho el depósito que establece la ley 11.723

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Principales temas sobre la adaptación del diagnóstico psiquiátrico y su clasificación para el uso en Salud Pública

Proyecto
El Futuro del Diagnóstico Psiquiátrico: Redefiniendo la Agenda de Investigación

Financiado por el American Psychiatric Institute for Research and Education (APIRE)
National Institutes of Health

OMS/APIRE Conferencia sobre Aspectos de Salud Pública de los Diagnósticos y las Clasificaciones

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Índice

Presentación **5**

1. Introducción **11**

2. Peso de la enfermedad en la población y evaluación de necesidades asistenciales **14**

2.1 Estudios destinados a estimar Prevalencia 14

2.2 Prevalencia por patología 15

2.3 Prevalencia por riesgo 15

2.4 Prevalencia por "conveniencia" 15

3. Taxonomías y prevalencia **15**

4. Determinar prioridades **16**

4.1 Prioridades según prevalencia 16

4.2 Según gravedad, riesgo, daño o peso social de la patología 16

4.3 Según disponibilidad de acciones de reparación (sensibilidad a la intervención) 16

5. Utilización de servicios (demanda efectiva) **16**

5.1 Estudios de demanda según diagnósticos y condiciones asociadas 17

5.2 Cuántos y qué tipos de servicios utilizan 17

6. La Brecha (*Gap*) entre necesidad detectada y demanda expresada **17**

7. Factores que deciden la consulta (*Help Seeking*) **18**

8. Evaluar resultados de las intervenciones **18**

9. Evaluar otros derivados diagnósticos o escalas **19**

10. Vigilancia epidemiológica **19**

11. Otros campos específicos: Desastres, conflictos armados, migraciones, minorías **20**

12. Conclusiones y recomendaciones **20**

Referencias bibliográficas **22**

Abstracts **29**

1. DSM-IV generalized anxiety disorder in the Australian National Survey of Mental Health and Well-Being 29

2. The lifetime prevalence, health services utilization and risk of suicide of bipolar spectrum subjects, including subthreshold categories in the Sao Paulo ECA study 30

3. Lifetime prevalence and age-of-onset distributions of DSM-IV disorders in the National Comorbidity Survey Replication. 31

4. A National Depression Index for Australia. 33

5. Lifetime and 12-month prevalence of DSM-III-R psychiatric disorders in the United States. Results from the National Comorbidity Survey. 34

6. Prevalence, severity, and comorbidity of 12-month DSM-IV disorders in the National Comorbidity Survey Replication. 35

7. Estimating the prevalence of mental and somatic disorders in the community: aims and methods of the German National Health Interview and Examination Survey....37

8. Lifetime and 12-month prevalence of DSM-III-R disorders in the Chile psychiatric prevalence study....38

9. Telephone surveys as an alternative for estimating prevalence of mental disorders and service utilization: a Montreal catchment area study. 39

10. Prevalence and correlates of personality disorder in Great Britain....40

11. Prevalence of depressive disorders in children and adolescents attending primary care. A survey with the Aquitaine Sentinelle Network. 41

12. Epidemiology of major depressive disorder: results from the National Epidemiologic Survey on Alcoholism and Related Conditions....44

13. Prevalence and comorbidity of psychiatric disorders in the French general population...45

14. Psychiatric disorders among at-risk consumers of alcohol in the general population. 47

15. Prevalence, correlates, and disability of personality disorders in the United States: results from the national epidemiologic survey on alcohol and related conditions. 48

16. The prevalence of depressive disorders in the United Kingdom....50

17. Screening for serious mental illness in the general population. 51

18. Short screening scales to monitor population prevalences and trends in non-specific psychological distress. 52

19. Assessing population need for mental health care: a review of approaches and predictors....53

20. Is the Australian National Survey of Mental Health and Wellbeing a reliable guide for health planners? A methodological note on the prevalence of depression. 55

21. Non-disabled cases in a national survey....56

22. Epidemiology of major depressive disorder: results from the National Epidemiologic Survey on Alcoholism and Related Conditions....57

23. Prevalence and Treatment of Mental Disorders, 1990 to 2003....58

24. Gaps in service utilization by Mexican Americans with mental health problems. 59

25. Prevalence, service use, and demographic correlates of 12-month DSM-IV psychiatric disorders in Mexico: results from the Mexican National Comorbidity Survey. 61

26. The DSM-IV rates of child and adolescent disorders in Puerto Rico: prevalence, correlates, service use, and the effects of impairment. 62

27. Los trastornos mentales en América Latina y el Caribe: asunto prioritario para la salud pública 63

28. Prevalence, Severity, and Unmet Need for Treatment of Mental Disorders in the World Health Organization World Mental Health Surveys....64

29. Utilization of specialty mental health care among persons with severe mental illness: the roles of demographics, need, insurance, and risk....65

30. The relationship between insurance coverage and psychiatric disorder in predicting use of mental health services. 67

31. Twelve-month use of mental health services in four areas in Japan: findings from the World Mental Health Japan Survey 2002-2003....68

32. Frequency and patterns of mental health services utilization among adolescents with anxiety and depressive disorders. 69

33. Mental disorders and service utilization among youths from homeless and low-income housed families. 70

34. Prevalence of mental disorders and utilization of mental health services in two American Indian reservation populations: mental health disparities in a national context....71

35. A gender-focused perspective on health service utilization in comorbid bipolar I disorder and alcohol use disorders: results from the national epidemiologic survey on alcohol and related conditions. 73

36. Utilization of health and mental health services. Three Epidemiologic Catchment Area sites. 74

37. Alcohol treatment utilization: Findings from the National Epidemiologic Survey on Alcohol and Related Conditions. 75

38. Use of health services in Puerto Rico by persons with mental disorders. 77

39. Factors related to utilization of services for mental health reasons in Montreal, Canada.78

40. Mental health service use in a nationally representative Canadian survey. 79

41. Prevalence of DSM-IV disorders and attendant help-seeking in 2 American Indian reservation populations. 80

42. Help-seeking for psychiatric disorders. 82

43. The relation between perceived need for mental health treatment, DSM diagnosis, and quality of life: a Canadian population-based survey....83

44. Delays in initial treatment contact after first onset of a mental disorder. 84

45. Social and economic determinants of disparities in professional help-seeking for child mental health problems: evidence from a national sample. 85

46. Assessing population need for mental health care: a review of approaches and predictors. 87

47. Global Assessment of Functioning ratings and the allocation and outcomes of mental health services. 88

48. Measuring outcomes in psychiatry: an inpatient model....89

49. Validation study of a nonspecific psychological distress scale. 90

50. Do older Australians truly have low rates of anxiety and depression? A critique of the 1997 National Survey of Mental Health and Wellbeing. 92

51. A general population comparison of the Composite International Diagnostic Interview (CIDI) and the Schedules for Clinical Assessment in Neuropsychiatry (SCAN). 93

52. Validation of the Edinburgh postpartum depression scale in a population of puerperal women in Mexico. 94

53. Validation of the Beck Depression Inventory-II in a low-income African American sample of medical outpatients. 95
54. Cross-cultural validation of the Beck Depression Inventory-II in Japan. 96
55. Different classification systems yield different dementia occurrence among nonagenarians and centenarians. 98
56. Comparison of different clinical diagnostic criteria for depression in Alzheimer disease. .99
57. The effect of different diagnostic criteria on the prevalence of dementia. 101
58. Common mental disorders in postconflict settings. 102
59. Psychiatric disability among tortured Bhutanese refugees in Nepal. 103
60. Psychological and psychopathological reactions in Honduras following Hurricane Mitch: implications for service planning. 104
61. Psychiatric morbidity among Afghan refugees in Peshawar, Pakistan. 105

Presentación

El reporte de Salud en el Mundo de 2001 hace un fuerte llamado a la integración del enfoque de Salud Pública para reducir el peso en el mundo de lo que se estima son 450 millones de personas con problemas de salud mental. Este reporte señala que "dada la magnitud del problema, la multifacético etiología, el persistente y serio estigma y discriminación y la brecha significativa entre necesidad y tratamientos a lo largo del mundo, un enfoque de Salud Pública es el método más apropiado para responder a tal necesidad".

La OMS define como objetivos de la Salud Pública en este campo:

- Formular políticas y planes nacionales y legislar, para mejorar la salud mental de las poblaciones
- Asegurar el acceso universal a servicios apropiados y costo-efectivos, incluyendo promoción, prevención y servicios de atención primaria
- Asegurar un cuidado adecuado y la protección de los derechos humanos para los pacientes con los desórdenes más severos y los institucionalizados, así como procurar el cuidado comunitario de los mismos
- Evaluar y monitorear la salud mental de las comunidades, incluyendo especialmente a las poblaciones vulnerables como niños, mujeres y ancianos.
- Promover estilos de vida saludables y reducir los factores de riesgo específicos para trastornos de salud mental
- Estimular la vida familiar estable, la cohesión social y el desarrollo humano, incluyendo estímulos para las organizaciones sociales y familiares
- Estimular la investigación sobre las causas de la enfermedad mental, el desarrollo de tratamientos efectivos y la evaluación de los sistemas asistenciales
- Desarrollar recursos humanos para los servicios de salud mental

La Salud Pública, como generalidad, refiere a todas las medidas, tanto públicas como privadas para promover la salud, prevenir la enfermedad, prolongar la vida y mejorar la riqueza y la calidad de la vida de la población en su conjunto. No obstante algún grado de control se ha logrado sobre enfermedades transmisibles, mucho queda por hacer en cuanto a la Salud Mental desde la perspectiva de Salud Pública; la cual aplica un enfoque multidisciplinario que comparte la responsabilidad con la población destinataria, con acciones intersectoriales y utilizando intervenciones técnicas de corrección de enfermedad, como así también legislativas, administrativas y de otros órdenes, como por ejemplo las educativas.

Entre las funciones esenciales de la Salud Pública, oportunamente establecidas por la OMS y aptas para reducir la carga de los problemas relacionados con la salud mental, se incluye el monitoreo de las condiciones de salud de las comunidades, las inequidades en salud y el

uso de los servicios por parte de la población. Todos estos aspectos han sido abordados en diversos estudios llevados a cabo en países con diverso grado de desarrollo, estudios que han abordado asimismo los modelos y la prevalencia en distintos dispositivos asistenciales, como los de atención primaria.

La función de vigilancia epidemiológica, otra de las nueve listadas por la OMS, ha sido llevada a cabo en temas de salud mental en el caso de poblaciones sometidas a desastres naturales o conflictos armados, con desplazamiento de personas a otras regiones. Algo menos se ha estudiado el uso de los servicios y la utilización de datos provenientes de estos para la elaboración de planes (ver informe SE No. 6 de esta misma serie).

Finalmente, la función de gestión estratégica de los servicios y sistemas ha sido aplicada a mejorar la accesibilidad, teniendo en cuenta la brecha señalada entre la necesidad y la oferta y el uso efectivo de los servicios.

La adecuada implementación de estas funciones de Salud Pública requiere de categorías diagnósticas confiables que respondan a intervenciones específicas, psicosociales y farmacológicas. El monitoreo y la vigilancia epidemiológica producen diferentes resultados dependiendo de qué tipo de sistema diagnóstico se utilice, y de allí pueden seguirse una serie de malos entendidos a lo largo de la cadena de significados, conclusiones y decisiones que siguen a la información

El objetivo de este trabajo ha sido obtener algún instrumento apto para aquellos propósitos, los de adecuar las referencias producidas por la investigación o la información proveniente de los servicios, a las funciones de Salud Pública.

Este informe constituye la elaboración de una parte de un grupo que trabajó en el tema de los manuales diagnósticos. Y a su vez este tema constituyó un capítulo dentro de un gran conjunto que también se explicará de modo de ayudar al lector a ubicar esta pequeña molécula en un compuesto mucho más ambicioso.

Los autores, Hugo Barrionuevo y Dante Graña, tomaron a su cargo comentar los "Aspectos principales a tener en cuenta al utilizar para propósitos de Salud Pública los manuales diagnósticos existentes.

Este grupo estuvo dirigido por el Jefe del Departamento de Salud Mental de la República de Chile, Alberto Minoletti e integrado por los autores y por Fred Kigozi de Uganda (experiencias exitosas con los actuales Manuales en países de bajo y mediano ingreso), Pichet Udomrain de Tailandia (problemas con los actuales Manuales en los países de bajos y medianos ingresos), Edgardo Perez de Canadá (cualidades que en los Manuales ayudan y son aptas para su uso en Salud Pública), Margarita Alegría de Puerto Rico (cómo mejorar la utilización de los sistemas de clasificación diagnóstica desde el punto de vista de la Salud Pública), y Francisco Torres de España (revisión de borradores).

El conjunto del trabajo se realizó bajo la supervisión de APIRE (Instituto Americano de Investigación Psiquiátrica, Grupo de trabajo de la Conferencia de Salud Pública)

A continuación se incluye, en su idioma original, los constituyentes de todo el grupo y la temática que fue abordada, siendo el presente informe

la porción correspondiente a "Aspectos relevantes a considerar en la transferencia o adaptación de los Manuales y Sistemas de Diagnóstico desde su original propósito clínico a las funciones de Salud Pública. Toda la tarea culminaba con una Conferencia Internacional en Septiembre de 2007. El trabajo se compuso desde julio de 2006 a marzo de 2007.

Plans for the WHO/APIRE Conference on Public Health Aspects of Diagnosis and Classification in September 2007

Brief Description of the Project

The planned Conference on Public Health Aspects of Diagnosis and Classification is the last in a series of 11 Conferences being organized by the American Psychiatric Institute for Research and Education (APIRE) as a part of the National Institutes of Health (NIH) of the USA supported project on The Future of Psychiatric Diagnosis: Refining the Research Agenda. The conferences are points of presentation of issues and available data concerning major groups of mental disorders. They are prepared and conducted by relevant working groups in collaboration with the Steering Committee of the project. The working groups work continuously during the projects' duration (2003-2007) to review research and other evidence and experience concerning areas assigned to them. They are expected to prepare the results of their explorations in the form of one or more scientific publications and to help other groups in their work. WHO is collaborating with APIRE on this project.

Leadership of the Public Health Conference Working Group

Professors Benedetto Saraceno and Norman Sartorius have accepted to Co-Chair the Public Health Conference Working Group that will: (i) review knowledge about the Public Health Aspects of Diagnosis and Classification in psychiatry, and (ii) plan a conference on Public Health Aspects of Diagnosis and Classification in September 2007. Professor Graham Thornicroft and Dr. Shekhar Saxena will act as Co-ordinators to the group. The other members of the Conference Working Group are: Professor John Cooper, and Dr. Darrel Regier.

Liaison with Other APIRE Working Groups

The Conference on Public Health Aspects of Diagnosis and Classification is one of the 11 Workshops to be convened as a part of this programme over the next 3 years. The other 10 Workshops are addressing:

- Diagnostic and Statistical Methods, (February 2004)
- Personality Disorders, (December 2004)
- Substance Abuse, (February 2004)
- Stress Induced and Fear Circuitry Disorders, (April 2005)
- Dementia, (September 2005)
- Deconstructing Psychosis, (February 2006)
- Obsessive Compulsive Behaviour Spectrums, (June 2006)
- Somatic Presentations, (September 2006)
- Externalising Disorders of Childhood, (February 2007)

- Depression and Generalised Anxiety Disorders, (June 2007)

To optimise collaborative working between the Public Health Working Group and other APIRE Working Groups we shall invite one member of each of the 10 other Working Groups to the Public Health conference to engage them in the issues we shall highlight that are related to the work of their groups.

Public Health Conference Expert Groups (CEG)
In preparation for the Public Health Conference, we are convening ten Conference Expert Groups (CEGs) who will collaborate with the Public Health Conference Working Group in planning the 2007 conference.

CEG	Lead
A. Forensic Issues	Professor Paul Mullen
B. Economic Consequences	Professor Howard Goldman
C. Statistics and Information Systems	Professor Walter Gulbinat
D. Public Relations, Education & Training	Professor H Dilling
E. Primary Care	Professor Linda Gask
F. Translation into Public Health Usage	Professor Alberto Minoletti
G. Stakeholder Perspectives	ProfessorGraham Thornicroft
H. Prevention of Mental disorders	Dr. Shekhar Saxena
I. Interface with ICD Z codes and ICF	Dr. Bedirhan Ustun
J. Public Health Implications of Definition of Mental Disorders	Professor Norman Sartorius

Outline contents of the Public Health Conference Expert Group reports

A. Forensic and Legal Issues
Key issues may include:
- Use of diagnoses and classifications in the practice of forensic psychiatry
- Capacity of patients to understand diagnostic and treatment information and decisions
- Provisions in Classification of mental disorders concerning chronicity and long term impairment
- Use of psychiatric diagnostic terms in law

B. Economic Consequences
Key issues may include:
- Diagnoses and classification in financing of mental health services
- Diagnoses and classification in relation to government mental health services
- Diagnoses and classification in relation to insurance, reimbursement and parity of care
- The Classification of mental disorders in relation to pensions and welfare benefit entitlements and definitions of invalidity
- Reflection of severity of impairment and distress in relevant classificatory definitions

C. Statistics and Information Systems

Key issues may include:

- Impact of new classifications on how countries collect and report statistics
- Training of diagnostic data coders
- Training of medical librarians
- Revision of ICD-10-CM (Clinical Modification) and other modifications
- Reporting systems for mental health conditions (e.g. suicide, mental retardation, substance use disorders)

D. Public Relations, Education and Training

Key issues may include:

- The introduction of the new diagnosis and classification systems into real life settings
- Preparation for and delivery of basic and advanced training in the new systems
- Training issues in relation to primary care (in liaison with Group E)
- Training for mental health specialists
- Training of medical students in matters related to the classification of mental disorders
- Use of diagnostic terms in public education

E. Primary Care

Key issues may include:

- Adaptation of new diagnosis and classification systems in primary care
- Implementation of these systems in primary care settings
- Training issues in relation to primary care (in liaison with Group D)

F. Translation into Public Health Usage

Key issues may include:

- Potential and actual conflicts of interest
- New syndromes and indications for pharmaceutical treatments (eg ADHD, and pre-menstrual syndrome, PTSD

G. Stakeholder Perspectives

Key issues may include:

- User perspectives on new systems of diagnosis and classification
- Carer perspectives on new systems of diagnosis and classification
- Lessons from renaming of schizophrenia in Japan
- May wish to commission survey of user and carer views on uses of systems of diagnosis and classification and the names used for conditions

H. Prevention of mental disorders

Key issues may include:

- Information on risk factors for diagnostic groups
- Reviewing the suitability of current diagnostic groups from risk factors and prevention perspective
- Advisability of incorporating prevention as one of the criteria for diagnostic groupings

I. Interface with ICD Z codes and ICF

(to be developed)

J. Public Health Implications of Definition of Mental Disorders

The definition of mental disorders has direct consequences for public health action. It affects the estimates of prevalence of disorders, the evaluation of the outcome of health interventions, the legal protection of people against abuse by psychiatry and by society and a number of other public health issues. The group will enumerate the public health issues related to the definition of mental disorders and suggest ways of ensuring that the definition of mental disorders helps patients as well as societies in their development.

Methods of Working for Conference Expert Groups

We expect that each Conference Expert Group will consist of between 4-8 members. The CEG leads should identify suitable members keeping in mind the need to include at least half the members from low and middle income countries and due consideration to achieving a regional and gender balance. The work of CEGs will consist mostly of phone conferences and correspondence by email, but they may take the opportunity to meet at conferences attended by members of each group. Each CEG is expected to produce a background paper on its key topic. Details of the suggested working of the CEGs are provided in the draft letter to the CEG leads.

Conference Venue

W.H.O., Geneva, Switzerland

Conference Date

September 2007 (exact dates to be confirmed)

Conference Participants

Participants will include leads of each of the Public Health Conference Expert Groups (10), a lead member from each of the other APIRE Working Groups (10), conference administrative staff (2-3) and a small number of invited participants to address key areas to be discussed (2-3). Details of the participants and budget for the conference are attached.

Publication

At this point, APIRE/APA anticipates both an overall summary report of each conference and key research recommendations in an appropriate peer reviewed journals for a given topic as well as a monograph to be published by the APA. The Co-Chairs of each conference (in this case Benedetto Saraceno and Norman Sartorius) will serve as Editors-in-Chief of their respective programs in collaboration with the Steering Committee of the project. APA/APIRE staff will provide editorial and logistical support for the publication process. CEGs will also be encouraged to publish separately the results of their initial review papers in consultation with the Chairs of the Conference working group. We suggest that each paper may eventually be submitted for publication in a suitable high impact peer-reviewed journal.

El tema F***, Translation into Public Health Usage*** es el que se aborda en el presente informe.

Dr. Dante Graña
Buenos Aires, Febrero de 2009

1. Introducción

La adaptación de un Manual de Diagnósticos Psiquiátricos para ser usado en las competencias públicas de Salud, que en este caso específico abordan los problemas de la Salud Mental, requiere de un proceso de conceptualización del problema y de otro de adaptación de la herramienta.

Los sistemas de clasificación actualmente en uso han partido de la observación de los casos que se presentaban a la exploración clínica y han sido diseñados para agruparlos según patrones considerados convenientes para el propósito diagnóstico y tambien para el terapéutico, siendo estos los ejes fundantes de las nosologías y cuyo propósito sustancial es la práctica clínica.

La utilización de la nosología en Salud Pública tiene particularidades derivadas de las propias funciones esenciales, definidas por la OMS y de acuerdo con ellas los instrumentos debieran permitir:

- medir carga de enfermedad y de discapacidad y el peso de estas condiciones para la sociedad, evaluando la presencia de inequidades en su distribución
- medir las variaciones en estas condiciones a lo largo del tiempo
- vigilar los cambios en la presentación de la enfermedad mental, tanto en cantidad como en calidad (vigilancia epidemiológica)
- medir el impacto en estas condiciones sobre la población a consecuencia de desastres naturales o como producto de conflictos o violencia
- planificar, diseñar, implementar y monitorear políticas aptas para el mejoramiento de la salud mental
- ser utilizado como herramienta de decisión en las políticas de regulación
- determinar las necesidades asistenciales en consonancia con las herramientas de reparación disponibles
- evaluar los resultados de intervenciones destinadas a prevenir o reparar la enfermedad mental
- ofrecer información útil para la gestión de los servicios de salud y su mejoramiento
- proveer de sistemas de referencia para investigaciones en temas de Salud Pública
- colaborar en la capacitación de profesionales de todo tipo, sirviendo como insumo para ello
- posibilitar la difusión de los problemas de salud mental entre la población y servir para la recomendación de conductas de salud y/o de prevención de riesgo
- permitir la adaptación de sus instrumentos de medida a los distintos contextos en que se produce la enfermedad y/o se brindan los servicios y/o se recaba información para uso en Salud Pública

La Salud Pública posee además ciertas particularidades, diferentes del uso clínico, que exigen a los sistemas de clasificación, y quizás más especialmente a sus productos derivados (herramientas para ser aplicadas a poblaciones), algunas características que mejoren su utilidad específica.

Características que debe tener para mejorar la aplicabilidad en Salud Pública:

- Accesibilidad de lenguaje, con rótulos que sean accesibles a la población (para servir como herramienta de promoción y prevención)
- Lenguaje neutro, tratando de reducir el estigma potencialmente inducido por la nomenclatura
- Simplicidad, para permitir su uso por encuestadores legos
- Factibilidad
- Operacionabilidad transcultural
- Utilizable para diagnósticos en servicios de salud
- Utilizable para educación de profesionales y auxiliares

A continuación hemos graficado nuestra conceptualización acerca de las demandas que la Salud Pública realiza a un Clasificador Diagnóstico en Salud Mental, a saber:

a) Evaluar necesidad
b) Determinar prioridades
c) Vigilancia epidemiológica
d) Medir la brecha entre estimado y manifiesto
e) Evaluar resultados de intervenciones / modalidades

En segundo término los campos particulares que requieren instrumentos especiales:

a) Atención Primaria
b) Atención especializada
c) Poblaciones vulnerables
d) Desastres, conflictos, etc.

Por último los tipos de instrumentos de aplicación de las clasificaciones

e) Evaluación discapacidad
f) Evaluación distress
g) Encuestas diagnósticas

El último objeto de estudio obedece a que las diferencias encontradas entre la demanda esperada o potencial y la demanda efectiva hacen prestar atención a las conductas de búsqueda de ayuda. Ellas son investigadas por los instrumentos de evaluación de necesidades y por herramientas psico-sociológicas.

CLASIFICACION DIAGNÓSTICA

Evaluar Necesidad

Determinar prioridades

UTILIDAD ESPERADA EN SALUD PÚBLICA

Vigilancia epidemiológica

Brecha entre estimado y manifiesto

Evaluar resultados de intervenciones/modalidades

Atrnción Primaria

Atención Especializada

CONTEXTOS

Poblaciones vulnerables

Desastres, conflictos, etc

HERRAMIENTAS DERIVADAS

Evaluación discapacidad

Encuestas diagnósticas

Evaluación distress

Determinantes de conductas de consulta

FUNCIONES DE SALUD PÚBLICA

SALUD PÚBLICA

Los actuales sistemas Internacionales de Clasificación Diagnóstica (CIE y DSM) han generado sus "herramientas derivadas" (encuestas estructuradas o semiestructuradas, escalas de gravedad) que han sido aplicados a las poblaciones para obtener información de las patologías prevalentes según las necesidades apuntadas.

Estos instrumentos han estado por supuesto en concordancia con los criterios clínicos que originaron el sistema taxonómico original, y las herramientas se han dirigido a evaluar globalmente presencia o ausencia de síntomas o bien han profundizado en la detección particular de algún problema determinado.

Con ellos se han producido estudios dirigidos a obtener información útil a la tarea de la Salud Pública, que son los que reseñamos en los apartados siguientes. Estos instrumentos son de diversa factura, pero en esencia están destinados a detectar la presencia de las condiciones que los sistemas de clasificación consideran que deben existir para calificar como "enfermo". Para que sean útiles estos "productos" deben poseer características de simplicidad, aplicabilidad y economía de recursos, condiciones propias de cualquier instrumento destinado a ser aplicado en extensión, además de la sensibilidad y especificidad, cualidades derivadas de los sistemas diagnósticos a los cuales representan.

2. Peso de la enfermedad en la población y evaluación de necesidades asistenciales

Los sistemas de clasificación, en su utilización sobre poblaciones, deben permitir discriminar entre sanos y no sanos o mejor, entre aquellos que necesitan o no una intervención de los sistemas de salud. El quantum de enfermedad (prevalencia, o más simplemente la cantidad de casos detectados) medida con los sistemas de clasificación vigentes, no refleja exactamente la necesidad, de acuerdo a los resultados de las investigaciones revisadas y que se citarán más adelante

2.1 Estudios destinados a estimar Prevalencia

En casi todo el mundo se han aplicado herramientas derivadas de los sistemas de clasificación diseñadas al efecto de cribar de una manera rápida y económica las personas que dan señales de padecer algún tipo de patología, de las que no ofrecen estas señales. [1 al 16]

La mayoría de estos estudios provienen de países de altos ingresos. Entre los realizados por países de bajos y medios ingresos mencionamos los de Brasil (San Pablo) , Chile, México, Puerto Rico [2,8,25,26,27]

En Salud Pública, y al efecto de proveer servicios preventivos y asistenciales, es importante conocer, además de la magnitud global de la enfermedad mental, otras circunstancias como la gravedad de los casos detectados o las magnitudes específicas de ciertos tipos de enfermedades, cuya distribución, severidad o sensibilidad a las intervenciones disponibles las hacen especialmente útiles desde la óptica del gestor de políticas.

Así distinguimos el interés por conocer la prevalencia por **patología**, por **riesgo** y por **"conveniencia"**.

2.2 Prevalencia por patología

Algunos estudios profundizan en algún síndrome o necesidad específica, en función de la importancia, de los requerimientos particulares de atención o de las posibilidades de implementar medidas aptas para reducir el impacto social del problema (prevalencia de depresión, cuadros de ansiedad, etc) . [1,2,3,4,10,12,13,14,20,22]

En otros estudios se intenta detectar además la severidad de la afección, medido por la discapacidad que genera.[6]

2.3 Prevalencia por riesgo

La identificación de factores que se presentan regularmente asociados a ciertas patologías posibilita acciones preventivas o asistenciales oportunas dirigidas a los grupos de mayor riesgo. Los sistemas de clasificación diagnóstica y sus herramientas de screening derivadas han posibilitado estudios de este tipo. La edad de comienzo de algunas enfermedades, la distribución geográfica, condiciones sociales, etc.) [3,10,11,12,14,29]

2.4 Prevalencia por "conveniencia"

La disponibilidad de acciones efectivas o capaces de impactar reduciendo la enfermedad o sus consecuencias focaliza la importancia de la información sobre la magnitud y la distribución de esas condiciones sensibles. Un ejemplo es la depresión que se hace manifiesta en los espacios de atención primaria general.

El creciente número de estudios sobre costo-efectividad de las intervenciones obligará a perfeccionar estos estudios dirigidos a aspectos específicos de la patología, desvinculados parcialmente del diagnóstico clínico y, como señalamos, más asociados a la posibilidad de intervención mediante políticas.

3. Taxonomías y prevalencia

Una observación derivada de los trabajos revisados y el valor en Salud Pública de un instrumento diagnóstico es la que se relaciona con la sensibilidad variada de los instrumentos de medida, en los cuales la inclusión o exclusión de un síntoma puede hacer variar la prevalencia con un rango importante de diferencia.

Esto se observa particularmente en la demencia, ya sea en el diagnóstico de la enfermedad [55,57] o en el de la comorbilidad. [56] Según se usen medios de evaluación derivados del DSM III, del CIE 10 o de instrumentos específicos de uso extendido en varios países como el CAMDEX (Cambridge Examination for Mental Disorders of the Elderly)

4. Determinar prioridades

Dentro de las funciones esenciales de la Salud Pública es preciso complementar la evaluación de necesidades con el establecimiento de prioridades, que permitan orientar la planificación y asignación de recursos. Para ello se tienen en cuenta variables distintas y más complejas, además de la prevalencia o cantidad de personas afectadas.

4.1 Prioridades según prevalencia

El apartado anterior mencionó los estudios de prevalencia y es redundante afirmar que las clasificaciones diagnósticas debieran permitir determinar esta magnitud con la mayor sensibilidad. Pero además estamos consignando que no es la única variable a tener en cuenta al momento de determinar prioridades en la asignación de recursos.

4.2 Según gravedad, riesgo, daño o peso social de la patología

Existen estudios que han escapado de las clasificaciones diagnósticas como eje de segmentación de casos para indagar sobre la magnitud del daño que la enfermedad produce, independientemente del nombre.

Para esta finalidad son más aptas las escalas que miden la discapacidad y la disfuncionalidad derivada de la enfermedad mental [17,18,21,49]. Estos estudios citados han mostrado que la discapacidad y/o la disfuncionalidad en general no son tributarias de una patología específica o determinada por nombre diagnóstico, y que las necesidades que generan sí son simétricas en función de la gravedad o la profundidad y por lo tanto más útiles a efecto de medir necesidades.

Utilizando estas escalas en los sistemas asistenciales se podría disponer de información útil a la salud pública dadas su practicidad, facilidad de aplicación y por la magnitud de la información que son capaces de proveer, siempre de acuerdo a los estudios citados.

4.3 Según disponibilidad de acciones de reparación (sensibilidad a la intervención)

Para Salud Pública es importante la definición de patologías o situaciones de dis-salud en términos de su abordabilidad. Esta es una característica que los sistemas actuales de clasificación diagnóstica no han considerado al momento de su creación; no obstante ello las modificaciones que se van produciendo persiguen bastante este criterio dado que son estimuladas por la aparición de instrumentos terapéuticos aptos.

5. Utilización de servicios (demanda efectiva)

Uno de los datos más significativos que los sistemas diagnósticos acercan para el uso en Salud Pública es el referido a la forma de utilizar los servicios disponibles. Esto implica determinar la cantidad y tipo de

servicios utilizados, según diagnósticos y otras condiciones de diversa naturaleza asociadas a la demanda.

Todos los trabajos que se encontraron en esta revisión utilizan la metodología de encuestas domiciliarias o telefónicas [9,16,39] para indagar a) si las personas sintieron la necesidad de consultar, y b) si consultaron efectivamente. Sólo un trabajo, de 1991 [38], investiga mirando en los servicios. Esta información aporta conocimiento sobre accesibilidad y otros aspectos relativos a la renuncia de las personas a demandar servicio.

5.1 Estudios de demanda según diagnósticos y condiciones asociadas

Las investigaciones intentan establecer qué condiciones asociadas a la percepción de necesidades llevan a la gente a solicitar el servicio. Parten de definir diagnósticos en la población y posteriormente condiciones asociadas. Se ha estudiado la influencia en la accesibilidad de:

a) la disposición de un seguro [29,30]

b) la severidad de la patología [10,39]

c) la comorbilidad [35,39]

d) la condición de urbano-rural [26,31]

e) la presencia de ideación suicida [32]

f) la vivienda y nivel de ingreso [33] y

g) algunas características de minorías, como los indígenas o migrantes [24,34,39].

5.2 Cuántos y qué tipos de servicios utilizan

Asimismo es importante determinar el volumen de los servicios demandados y las condiciones que lo determinan [29,31,36] así como el tipo de profesional consultado [23]

6. La Brecha (*Gap*) entre necesidad detectada y demanda expresada

Uno de los hallazgos provenientes de las encuestas domiciliarias que buscan determinar la demanda efectiva es el de que una buena parte de quienes dan positivo para un diagnóstico en los clasificadores actuales, no consultan efectivamente y, paradojalmente, una porción de la población que ha consultado no es portadora de criterios de trastorno para esos clasificadores. [23 al 28]

Este fenómeno, denominado "gap" entre "necesidad" y "demanda" ha sido el punto de partida de estudios que intentan explicarla.

La primer hipótesis supone que se trata de un problema de accesibilidad, y de allí los estudios ya citados que abordan las condiciones asociadas a la dificultad de acceso, como nivel de ingreso, urbano-rural, minorías, sexo, cobertura, etc.

En segundo lugar las hipótesis transcurren por el camino de la percepción subjetiva de la necesidad en las personas que marcan positivo en las encuestas y su conducta de consulta [43,44,45].

Algunos trabajos intentan una tercera línea de reflexión centrada en la capacidad de detección de la clasificación y sus herramientas derivadas, apuntando a temas de sensibilidad de los instrumentos[2,19,49,50,51,55,56,57]

Otra línea de reflexión apunta a la demora en la consulta, mostrando que entre la aparición de las síntomas y la consulta existe un largo período, de más de 10 años en promedio, que explicaría los casos de diagnóstico positivo pero sin consulta [44]

Lo concreto es que a efectos de determinar las necesidades para la Salud Pública, la herramienta actualmente disponible resulta insuficiente y la inferencia mediante su utilización parece bastante poco conveniente.

7. Factores que deciden la consulta (*Help Seeking*)

El fenómeno de la brecha ya mencionado en los párrafos anteriores lleva a algunos investigadores a preguntarse por los factores que influyen en las conductas de consulta, encontrando algunos determinantes presuntamente culturales [41], la comorbilidad [42], el nivel de afectación de la calidad de vida [43], las ideas de suicidio [43] y entre los infantes el género, la posición en el grupo y la presencia de padre [45].

El único factor que se asocia con la variable diagnóstico es la comorbilidad, en la cual la presencia de un segundo trastorno incrementa la chance de consultar. Este es un dato que se repite en todos los estudios.[8,12,35,37,42]

Cuando se investiga qué otras asociaciones entre las exploradas pueden aproximarse con mayor sensibilidad al uso de servicios aparece mencionado en algunos casos la inclusión de los cuadros subclínicos (subthreshold) [2] , pero las menciones más extensas se dirigen a la evaluación de la discapacidad o el distress, mediante escalas específicas. Los casos que acusan un mayor nivel de distress, o discapacidad medida con las escalas GAF son los que presentan mayores niveles de consulta. [17,18,21,25,29,42,43]

Esto lleva a pensar que desde el punto de vista de la Salud Pública la disposición de una escala simple para medir distress o discapacidad podría ser más útil en la evaluación de requerimientos de servicios, al menos en lo que hace a la demanda efectivamente expresada. [18]

8. Evaluar resultados de las intervenciones

Un sistema diagnóstico para uso en Salud Pública debiera dar cuenta de los niveles de gravedad de una situación de enfermedad y de sus cambios producto de las intervenciones producidas. En el caso de Salud Mental y las alteraciones del comportamiento o la desadaptación, las clasificaciones proveen una medida precaria del quantum de enfermedad o de gravedad.

La escala utilizada es la de discapacidad (GAF), que puede servir también para evaluar los resultados de las intervenciones, aunque carece de la sensibilidad necesaria para medir la intensidad de tratamientos requeridos[47,48]

9. Evaluar otros derivados diagnósticos o escalas

La clasificación diagnóstica constituye un punto de partida para el desarrollo de herramientas derivadas que son a su vez utilizadas como *gold standard* para la evaluación de otras escalas.

Llamamos herramientas derivadas a los cuestionarios desarrollados para detectar presencia de criterios que definen enfermedad, como el CIDI y otros. Estos cuestionarios se convierten en comparadores para las otras escalas, que pueden ser más o menos sensibles o específicas. De este modo las escalas cuantitativas para registrar intensidad de síntomas, discapacidad o *distress*, buscan obtener sus puntos de corte mediante la comparación con los sistemas diagnósticos mediada por las herramientas derivadas. [49,51,52,53,54]

La disponibilidad de escalas es un auxiliar de importancia en la detección de casos en poblaciones, y muy especialmente cuando se las utiliza para complementar el diagnóstico cuando la sintomatología no supera el umbral de sensibilidad de las clasificaciones.

10. Vigilancia epidemiológica

La función de vigilar el estado de salud de la población y detectar cambios inesperados capaces de generar alteraciones en la salud de las poblaciones constituye uno de las actividades esenciales de la Salud Pública. Si bien la vigilancia nació y se desarrolló especialmente para los casos de enfermedades transmisibles, la transición epidemiológica obliga a un esfuerzo por instalar sistemas destinados a la detección de cambios relacionados con las patologías no transmisibles.

En Salud Mental por ahora es poco el espectro de problemas que han sido objeto de vigilancia, pero es indudable que se instalarán en el futuro, especialmente los enfocados a violencia, uso de sustancias y suicidio, además del posible monitoreo de trastornos mentales graves y persistentes. Para ello será necesario incluir categorías específicas o modificar los criterios de las taxonomías actualmente en uso de modo de conformar el objetivo de percibir los cambios y de administrar medidas oportunas de control.

Una investigación desarrollada en Argentina (ver informe SE No. 6 de esta misma serie) mostró factible y de gran utilidad la utilización de la información proveniente de los sistemas asistenciales existentes. En ese país se produce un volumen significativo de información que podría aprovecharse mejorando las condiciones de registro, recolección y análisis.

11. Otros campos específicos: Desastres, conflictos armados, migraciones, minorías

El daño producido por las situaciones de desastre y otras circunstancias que afectan traumáticamente a grandes poblaciones, como las migraciones, conflictos armados y confrontaciones étnicas con minorías discriminadas, reclama de los sistemas de salud una preocupación y una respuesta adecuada.

Los estudios realizados en estos grupos muestran tasas importantes de lo que podríamos englobar en el criterio de Stress Postraumático. Pero la diversidad de situaciones y la importancia de los componentes socio-ambientales obligan al desarrollo de herramientas de agrupamiento apropiadas para un enfoque sistémico y apto para la intervención eficaz.

Los trabajos que relatan experiencias de ayuda en estas poblaciones mencionan que las tareas de Salud Mental debieran estar dirigidas al cuidado y capacitación del personal de los sistemas regulares de atención, [58 al 62] además de la atención específica de las situaciones traumáticas.

12. Conclusiones y recomendaciones

Luego de analizar el material colectado para revisión, podemos comentar lo siguiente:

1. A los efectos de medir la carga de enfermedad y discapacidad los instrumentos provenientes de ambos sistemas diagnósticos (CIE y DSM) han mostrado ser operables y permitir la detección de inequidades.
2. De igual manera, y con las limitaciones que se comentarán luego, son capaces, a su modo, de detectar variaciones en el tiempo, aunque estas, a excepción de las situaciones de desastres, no son notables en la patología mental (las pendientes de cambios son muy suaves)
3. Al efecto del planeamiento de políticas y servicios hay una discrepancia entre lo que detectan las encuestas de población y la demanda que efectivamente se expresa en los servicios. Del mismo modo una buena proporción de quienes demandan atención no tienen diagnósticos evidenciables según los sistemas existentes.
4. Las consecuencias patológicas de los desastres (naturales o provocados) en la salud mental son incluidas generalmente en el diagnóstico de Estrés Postraumático. La frecuencia y particularidad de estos eventos hace conveniente la disposición de un clasificador apropiado.
5. Para la finalidad del planeamiento de servicios es más útil el agrupamiento según requerimiento de dispositivo asistencial, que está más vecino a la gravedad que a la categoría clínica.

6. El comentario anterior es válido también a efectos de la gestión cotidiana de los servicios especializados.
7. A los efectos de la investigación clínica las categorías existentes no parecen necesitar cambios; los que sí son necesarios en términos de más sensibilidad y especificidad para las investigaciones en población.
8. Habiendo encontrado en la literatura varios trabajos que utilizan el teléfono como una manera rápida y sobre todo económica de obtener información epidemiológica, y muy especialmente para servicios (utilización, accesibilidad, necesidad, expectativas, etc) nos pareció adecuado considerar la posibilidad de generar una lista rápida de preguntas basada en necesidades asistenciales y de posible utilización en la confección de encuestas para ser implementadas por teléfono.

Escalas de gravedad

Algunas herramientas disponen de medios de evaluación de severidad, [12,21,25,43] o los investigadores han adaptado escalas de severidad que evalúan otras situaciones existentes, aunque no estrictamente clínicas, tales como la discapacidad o el *distress*. [17, 18,49]

Utilizando estas escalas en los sistemas asistenciales se podría disponer de información útil a la gestión de los servicios dadas su practicidad, facilidad de aplicación y la magnitud de la información que son capaces de proveer, de acuerdo a los estudios citados.

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Abstracts

1. DSM-IV generalized anxiety disorder in the Australian National Survey of Mental Health and Well-Being.

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School of Psychology, University of Sydney, NSW, Australia.

Psychol Med. 2002 May;32(4):649-59.

BACKGROUND: This paper reports population data on DSM-IV generalized anxiety disorder from the Australian National Survey of Mental Health and Well-Being.

METHODS: The data were obtained from a nationwide household survey of adults using a stratified multi-stage sampling process. A response rate of 78.1% resulted in 10,641 persons being interviewed. Diagnoses were made using the Composite International Diagnostic Interview. The interview was computerized and conducted by trained lay interviewers. RESULTS: Prevalence in the total sample was 2.8% for 1-month GAD and 36% for 12-month GAD. Persons over 55 years of age were less likely to have GAD than those in the younger age groups. Logistic regression analysis also showed that a diagnosis of GAD was significantly associated with being of younger to middle age, being separated divorced or widowed, not having tertiary qualifications or being unemployed. Co-morbidity with another affective, anxiety, substance use or personality disorders was common, affecting 68% of the sample with 1-month DSM-IV GAD. GAD was associated with significant disablement, and 57% of the sample with DSM-IV GAD had consulted a health professional for a mental health problem in the prior 12 months. CONCLUSIONS: The survey provides population data on DSM-IV GAD and its correlates. GAD is a common disorder that is accompanied by significant morbidity and high rates of co-morbidity with affective and anxiety disorders, and is associated with marital status, education, employment status, but not sex. Changes to DSM-IV diagnostic criteria did not appear to affect the prevalence rate compared to previous population surveys.

PMID: 12102379 [PubMed - indexed for MEDLINE]

Related Links

DSM-III-R generalized anxiety disorder in the National Comorbidity Survey. [Arch Gen Psychiatry. 1994]

PMID:8179459

Generalized Anxiety Disorder and major depressive disorder comorbidity in the National Survey of Mental Health and Well-Being. [Depress Anxiety. 2004]

PMID:15368593

Prevalence, correlates, co-morbidity, and comparative disability of DSM-IV generalized anxiety disorder in the USA: results from the National

Epidemiologic Survey on Alcohol and Related Conditions. [Psychol Med. 2005]

PMID:16202187

Prevalence, co-morbidity and correlates of mental disorders in the general population: results from the German Health Interview and Examination Survey (GHS). [Psychol Med. 2004]

PMID:15099415

Generalised anxiety disorder in Singapore: prevalence, co-morbidity and risk factors in a multi-ethnic population. [Soc Psychiatry Psychiatr Epidemiol. 2005]

PMID:16249971

1: J Affect Disord. 2005 Aug;87(2-3):231-41.

2. The lifetime prevalence, health services utilization and risk of suicide of bipolar spectrum subjects, including subthreshold categories in the Sao Paulo ECA study

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BACKGROUND: Identifying the bipolar (BP) spectrum, including the classic Bipolar I subtype (BP-I), Bipolar II (BP-II) and subthreshold bipolar disorders not meeting DSM-IV diagnostic criteria has raised growing interest, as these softer expressions of bipolar spectrum have been underdiagnosed in spite of clinical consequences. METHODS: Data are from the Sao Paulo Epidemiological Catchment Area Study (N=1464). Non-affective controls were compared to BP spectrum groups, based on DSM-IIIR and on the "clinical significance" criteria: Subsyndromal Hypomania (SSH) and Manic Symptoms (MS). RESULTS: The lifetime prevalence of BP subgroups was 8.3% (N=122). All BP-I and -II and around 75% of SSH and MS subjects had a lifetime depressive syndrome. Compared to controls and MS subjects, BP-I, BP-II and SSH groups searched more medical help and mental health services. SSH group displayed higher rates of clinical significance than BP-I subjects, and suicidality was higher in BP groups compared to controls. Even the softer MS group had higher rate of suicide attempts than SSH subjects. LIMITATIONS: This is a cross-sectional study and interviews were conducted by lay personnel. Replication in bigger community samples using a mood spectrum approach is necessary to confirm these findings. However, our findings were very similar to those obtained by other authors. CONCLUSION: Softer expressions of BP disorders appear in 6.6% of this community sample and have serious clinical consequences, which supports the importance of including these categories in the BP spectrum.

PMID: 16009430 [PubMed - indexed for MEDLINE]

Related Links

The prevalence and disability of bipolar spectrum disorders in the USpopulation: re-analysis of the ECA database taking into account subthreshold cases. [J Affect Disord. 2003]

PMID:12507745

History of suicide attempts in pediatric bipolar disorder: factors associated with increased risk. [Bipolar Disord. 2005]

PMID:16403178

Phenomenology of children and adolescents with bipolar spectrum disorders. [Arch Gen Psychiatry. 2006]

PMID:17015816

Threshold and subthreshold bipolar disorders in the Sesto Fiorentino Study. [J Affect Disord. 2006]

PMID:16701902

Toward a re-definition of subthreshold bipolarity: epidemiology and proponed criteria for bipolar-II, minor bipolar disorders and hypomania. [J Affect Disord. 2003]

PMID:12507746

1: Arch Gen Psychiatry. 2005 Jun;62(6):593-602.

3. Lifetime prevalence and age-of-onset distributions of DSM-IV disorders in the National Comorbidity Survey Replication.

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CONTEXT: Little is known about lifetime prevalence or age of onset of DSM-IV disorders. OBJECTIVE: To estimate lifetime prevalence and age-of-onset distributions of DSM-IV disorders in the recently completed National Comorbidity Survey Replication. DESIGN AND SETTING: Nationally representative face-to-face household survey conducted between February 2001 and April 2003 using the fully structured World Health Organization World Mental Health Survey version of the Composite International Diagnostic Interview. PARTICIPANTS: Nine thousand two hundred eighty-two English-speaking respondents aged 18 years and older. MAIN OUTCOME MEASURES: Lifetime DSM-IV anxiety, mood, impulse-control, and substance use disorders. RESULTS: Lifetime prevalence estimates are as follows: anxiety disorders, 28.8%; mood disorders, 20.8%; impulse-control disorders, 24.8%; substance use

disorders, 14.6%; any disorder, 46.4%. Median age of onset is much earlier for anxiety (11 years) and impulse-control (11 years) disorders than for substance use (20 years) and mood (30 years) disorders. Half of all Lifetime cases start by age 14 years and three fourths by age 24 years. Later onsets are mostly of comorbid conditions, with estimated lifetime risk of any disorder at age 75 years (50.8%) only slightly higher than observed lifetime prevalence (46.4%). Lifetime prevalence estimates are higher in recent cohorts than in earlier cohorts and have fairly stable intercohort differences across the life course that vary in substantively plausible ways among sociodemographic subgroups. CONCLUSIONS: About half of Americans will meet the criteria for a DSM-IV disorder sometime in their life, with first onset usually in childhood or adolescence. Interventions aimed at prevention or early treatment need to focus on youth.

PMID: 15939837 [PubMed - indexed for MEDLINE]

Related Links

The prevalence and correlates of DSM-IV intermittent explosive disorder in the National Comorbidity Survey Replication. [Arch Gen Psychiatry. 2006]

PMID:16754840

Prevalence, severity, and comorbidity of 12-month DSM-IV disorders in the National Comorbidity Survey Replication. [Arch Gen Psychiatry. 2005]

PMID:15939839

Failure and delay in initial treatment contact after first onset of mental disorders in the National Comorbidity Survey Replication. [Arch Gen Psychiatry. 2005]

PMID:15939838

Prevalence and correlates of estimated DSM-IV child and adult separation anxiety disorder in the National Comorbidity Survey Replication. [Am J Psychiatry. 2006] PMID:16741209

Lifetime prevalence and projected lifetime risk of DSM-IV disorders in Te Rau Hinengaro: the New Zealand Mental Health Survey. [Aust N Z J Psychiatry. 2006]

PMID:16959012

1: Med J Aust. 2004 Oct 4;181(7 Suppl):S52-6.

4. A National Depression Index for Australia.

Mackinnon A, Jorm AF, Hickie IB.

Mental Health Research Institute of Victoria, Department of Psychological Medicine, Monash University, Locked Bag 11, Parkville, VIC 3052, Australia. ajm@mhri.edu.au.

OBJECTIVE: To develop a National Depression Index for measuring the depression status of the Australian population. DESIGN: Cross-sectional data were analysed from two random samples of the Australian adult population - the National Survey of Mental Health and Wellbeing (2000) and the National Health Survey (2001).

PARTICIPANTS: The National Survey of Mental Health and Wellbeing (2000) - 10 641 participants; and the National Health Survey (2001) - 17 918 participants. MAIN OUTCOME MEASURES: Selected items from the Kessler Psychological Distress Scale (K10); and diagnoses of a major depressive episode according to DSM-IV criteria using a computerised interview. RESULTS: Six items from the K10 that were most closely related to the DSM-IV diagnosis of "major depressive episode" were identified. Scores on an index calculated from these items were rescaled to form an index reflecting relative risk of depression and having a value of 100 for the Australian adult population. Taking into account sex, employment status and income, index values were higher in younger people, females, unemployed people and those socioeconomically disadvantaged. This pattern provides additional support for the validity of the index, as well as establishing benchmark levels to which index values from future surveys and in other groups may be compared.

CONCLUSIONS: The proposed National Depression Index is a valid indicator of depression and level of depressive symptoms. It is suitable for monitoring depression at the population level. The scaling characteristics of the measure ensure that it can be interpreted by members of the general public.

PMID: 15462643 [PubMed - indexed for MEDLINE]

Related Links

Prevalence and correlates of DSM-IV major depression in an Australian national survey. [J Affect Disord. 2003]

PMID:12798255

Evaluation of the Neurobehavioral Functioning Inventory as a depression screening tool after traumatic brain injury. [J Head Trauma Rehabil. 2005]

PMID:16304488

Do older Australians truly have low rates of anxiety and depression? A critique of the 1997 National Survey of Mental Health and Wellbeing. [Aust N Z J Psychiatry. 2006]

PMID:16866757

Depression with atypical features in the National Comorbidity Survey: classification, description, and consequences. [Arch Gen Psychiatry. 2003]

PMID:12912765

DSM-IV generalized anxiety disorder in the Australian National Survey of Mental Health and Well-Being. [Psychol Med. 2002]

PMID:12102379

1: Arch Gen Psychiatry. 1994 Jan;51(1):8-19.

5. Lifetime and 12-month prevalence of DSM-III-R psychiatric disorders in the United States. Results from the National Comorbidity Survey.

Kessler RC, McGonagle KA, Zhao S, Nelson CB, Hughes M, Eshleman S, Wittchen HU,

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Institute for Social Research, University of Michigan, Ann Arbor.

BACKGROUND: This study presents estimates of lifetime and 12-month prevalence of 14 DSM-III-R psychiatric disorders from the National Comorbidity Survey, the first survey to administer a structured psychiatric interview to a national probability sample in the United States. METHODS: The DSM-III-R psychiatric disorders among persons aged 15 to 54 years in the noninstitutionalized civilian population of the United States were assessed with data collected by lay interviewers using a revised version of the Composite International Diagnostic Interview. RESULTS: Nearly 50% of respondents reported at least one lifetime disorder, and close to 30% reported at least one 12-month disorder. The most common disorders were major depressive episode, alcohol dependence, social phobia, and simple phobia. More than half of all lifetime disorders occurred in the 14% of the population who had a history of three or more comorbid disorders.

These highly comorbid people also included the vast majority of people with severe disorders. Less than 40% of those with a lifetime disorder had ever received professional treatment, and less than 20% of those with a recent disorder had been in treatment during the past 12 months. Consistent with previous risk factor research, it was found that women had elevated rates of affective disorders and anxiety disorders, that men had elevated rates of substance use disorders and antisocial personality disorder, and that most disorders declined with age and with higher socioeconomic status.

CONCLUSIONS: The prevalence of psychiatric disorders is greater than previously thought to be the case. Furthermore, this morbidity is more highly concentrated than previously recognized in roughly one sixth of the population who have a history of three or more comorbid disorders. This suggests that the causes and consequences of high comorbidity should be

the focus of research attention. The majority of people with psychiatric disorders fail to obtain professional treatment. Even among people with a lifetime history of three or more comorbid disorders, the proportion who ever obtain specialty sector mental health treatment is less than 50%. These results argue for the importance of more outreach and more research on barriers to professional help-seeking.

PMID: 8279933 [PubMed - indexed for MEDLINE]

Related Links

DSM-III-R generalized anxiety disorder in the National Comorbidity Survey.

[Arch Gen Psychiatry. 1994]

PMID:8179459

Comorbidity of DSM-IV pathological gambling and other psychiatric disorders: results from the National Epidemiologic Survey on Alcohol and Related Conditions. [J Clin Psychiatry. 2005]

PMID:15889941

Prevalence of DSM-IV disorders and attendant help-seeking in 2 American Indian reservation populations. [Arch Gen Psychiatry. 2005]

PMID:15630077

Current comorbidity of psychiatric disorders among DSM-IV major depressive disorder patients in psychiatric care in the Vantaa Depression Study. [J Clin Psychiatry. 2002]

PMID:11874213

Prevalence of psychiatric disorders among persons convicted of driving while impaired. [Arch Gen Psychiatry. 2001]

PMID:11576032

1: Arch Gen Psychiatry. 2005 Jun;62(6):617-27.

6. Prevalence, severity, and comorbidity of 12-month DSM-IV disorders in the National Comorbidity Survey Replication.

Kessler RC, Chiu WT, Demler O, Merikangas KR, Walters EE.

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BACKGROUND: Little is known about the general population prevalence or severity of DSM-IV mental disorders. OBJECTIVE: To estimate 12-month prevalence, severity, and comorbidity of DSM-IV anxiety, mood, impulse

control, and substance disorders in the recently completed US National Comorbidity Survey Replication. DESIGN AND SETTING: Nationally representative face-to-face household survey conducted between February 2001 and April 2003 using a fully structured diagnostic interview, the World Health Organization World Mental Health Survey Initiative version of the Composite International Diagnostic Interview. PARTICIPANTS: Nine thousand two hundred eighty-two English-speaking respondents 18 years and older. MAIN OUTCOME MEASURES: Twelve-month DSM-IV disorders. RESULTS: Twelve-month prevalence estimates were anxiety, 18.1%; mood, 9.5%; impulse control, 8.9%; substance, 3.8%; and any disorder, 26.2%. Of 12-month cases, 22.3% were classified as serious; 37.3%, moderate; and 40.4%, mild. Fifty-five percent carried only a single diagnosis; 22%, 2 diagnoses; and 23%, 3 or more diagnoses. Latent class analysis detected 7 multivariate disorder classes, including 3 highly comorbid classes representing 7% of the population.

CONCLUSION: Although mental disorders are widespread, serious cases are concentrated among a relatively small proportion of cases with high comorbidity.

PMID: 15939839 [PubMed - indexed for MEDLINE]

Related Links

Lifetime prevalence and age-of-onset distributions of DSM-IV disorders in the National Comorbidity Survey Replication. [Arch Gen Psychiatry. 2005]

PMID:15939837

The prevalence and correlates of DSM-IV intermittent explosive disorder in the National Comorbidity Survey Replication. [Arch Gen Psychiatry. 2006]

PMID:16754840

Twelve-month use of mental health services in the United States: results from the National Comorbidity Survey Replication. [Arch Gen Psychiatry. 2005]

PMID:15939840

The epidemiology of major depressive disorder: results from the National Comorbidity Survey Replication (NCS-R). [JAMA. 2003]

PMID:12813115

Clinical differences among patients treated for mental health problems in general medical and specialty mental health settings in the National Comorbidity Survey Replication. [Gen Hosp Psychiatry. 2006]

PMID:16950373

1: Int J Methods Psychiatr Res. 2002;11(1):1-18.

7. Estimating the prevalence of mental and somatic disorders in the community: aims and methods of the German National Health Interview and Examination Survey.

Jacobi F, Wittchen HU, Holting C, Sommer S, Lieb R, Hofler M, Pfister H. Institute of Clinical Psychology and Psychotherapy, Unit, Technical University of Dresden, Germany. jacobi@psychologie.tu-dresden.de

This paper outlines the principal aims and design of the German National Health Interview and Examination Survey, mental health supplement (GHS-MHS), the first nationwide, epidemiological study of both somatic and mental health in Germany on a representative sample of 4,181 subjects in the community. Both the broader context of the study--in particular its methodological relation to the social and somatic core survey of the German National Health Interview and Examination Survey (GHS-CS)--and the internal methodology of the mental health supplement (GHS-MHS) are presented. The study's strategies and method are derived from a consideration of important theoretical issues arising from epidemiological studies in the field of public health. The main instrument used to assess diagnoses of mental disorders was a standardized diagnostic interview for mental disorders (following DSM-IV (CIDI)) applied by clinically trained interviewers.

This diagnostic interview was supplemented by modules on comorbidity, help seeking, treatment and impairment. Somatic health diagnoses were made using an integrated approach including self-report measures, a standardized clinical interview, and laboratory measures. Findings on sampling, response rate, weighting and sample characteristics are presented. Critical issues are discussed, including the scientific objectives that have been achieved by the study. Overall, the GHS core survey and its mental health supplement provide the mental health research community with complex data that allow for high-quality analysis of mental disorders and associations with somatic disorders.

PMID: 12459800 [PubMed - indexed for MEDLINE]

Related Links

Prevalence, co-morbidity and correlates of mental disorders in the general population: results from the German Health Interview and Examination Survey (GHS). [Psychol Med. 2004]

PMID:15099415

[Affective, somatoform and anxiety disorders in Germany--initial results of an additional federal survey of "psychiatric disorders"] [Gesundheitswesen. 1999]

PMID:10726424

Prevalence of DSM-IV disorders and attendant help-seeking in 2 American Indian reservation populations. [Arch Gen Psychiatry. 2005]

PMID:15630077

[Methodology of a study on insomnia in the general population] [Encephale. 2002]

PMID:12091782

[Prevalence of depressive disorders in children and adolescents attending primary care. A survey with the Aquitaine Sentinelle Network] [Encephale. 2003]

PMID:14615688

1: Am J Psychiatry. 2006 Aug;163(8):1362-70.

8. Lifetime and 12-month prevalence of DSM-III-R disorders in the Chile psychiatric prevalence study.

Vicente B, Kohn R, Rioseco P, Saldivia S, Levav I, Torres S.

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OBJECTIVE: Although several epidemiological studies of the prevalence of psychiatric disorders have been conducted in Latin America, few of them were national studies that could be used to develop region-wide estimates. Data are presented on the prevalence of DSM-III-R disorders, demographic correlates, comorbidity, and service utilization in a nationally representative adult sample from Chile. METHOD: The Composite International Diagnostic Interview was administered to a stratified random sample of 2,978 individuals from four provinces representative of the country's population age 15 and older. Lifetime and 12-month prevalence rates were estimated. RESULTS: Approximately one-third (31.5%) of the population had a lifetime psychiatric disorder, and 22.2% had a disorder in the past 12 months. The most common lifetime psychiatric disorders were agoraphobia (11.1%), social phobia (10.2%), simple phobia (9.8%), major depressive disorder (9.2%), and alcohol dependence (6.4%). Of those with a 12-month prevalence diagnosis, 30.1% had a comorbid psychiatric disorder. The majority of those with comorbidity had sought out mental health services, in contrast to one-quarter of those with a single disorder. CONCLUSIONS: The prevalence rates in Chile are similar to those obtained in other studies conducted in Latin America and Spanish-speaking North American groups. Comorbidity and alcohol use disorders, however, were not as prevalent as in North America.

PMID: 16877648 [PubMed - indexed for MEDLINE]

Related Links

Population prevalence of psychiatric disorders in Chile: 6-month and 1-month rates. [Br J Psychiatry. 2004]

PMID:15056573

Lifetime and 12-month prevalence of DSM-III-R psychiatric disorders in the United States. Results from the National Comorbidity Survey. [Arch Gen Psychiatry. 1994]

PMID:8279933

Prevalence of DSM-IV disorders and attendant help-seeking in 2 American Indian reservation populations. [Arch Gen Psychiatry. 2005]

PMID:15630077

[Chilean study on the prevalence of psychiatric disorders (DSM-III-R/CIDI) (ECPP)] [Rev Med Chil. 2002]

PMID:12143273

Comorbidity of DSM-IV pathological gambling and other psychiatric disorders: results from the National Epidemiologic Survey on Alcohol and Related Conditions. [J Clin Psychiatry. 2005]

PMID:15889941

1: Can J Psychiatry. 1997 Sep;42(7):737-43.

9. Telephone surveys as an alternative for estimating prevalence of mental disorders and service utilization: a Montreal catchment area study.

Fournier L, Lesage AD, Toupin J, Cyr M.

Centre de recherche Philippe Pinel, Montreal, Quebec.

BACKGROUND: Large-scale mental health surveys have provided invaluable information regarding the prevalence of specific mental disorders and service use for mental health reasons. Unfortunately, because vast surveys conducted face to face are very costly, many countries and provinces do not embark upon this path of research, thus depriving themselves of a rich source of data useful for service planning. METHOD: As an alternative, the authors undertook a telephone survey with a sample of 893 residents from a Montreal catchment area. Mental disorders were assessed by the Composite International Diagnostic Interview Simplified (CIDIS), an instrument especially designed to be used in mail or telephone surveys. Service utilization was measured by an instrument similar to those used in recent large Canadian or American surveys. RESULTS: The prevalence rate for any mental disorder was lower in this study than in some large-scale epidemiological surveys reviewed. This could be explained by methodological differences, such as number of

disorders covered and period of reference. With regard to specific mental disorders, results appeared very similar to those of other studies. Concerning service utilization, rates tended to be higher than in other studies, and this finding could reflect real differences between Quebec and other Canadian provinces or the United States.

CONCLUSIONS: Aside from being lower in cost, telephone surveys can yield results comparable to those obtained in large-scale epidemiological surveys conducted by means of face-to-face interviews.

PMID: 9307834 [PubMed - indexed for MEDLINE]

Related Links

A comparison of mail and telephone interview strategies for mental health surveys. [Can J Psychiatry. 1993]

PMID:8242527

Validation study of a nonspecific psychological distress scale. [Soc Psychiatry Psychiatr Epidemiol. 2005]

PMID:16215656

Service use for mental health reasons: cross-provincial differences in rates, determinants, and equity of access. [Can J Psychiatry. 2005]

PMID:16276852

[Methodology of a study on insomnia in the general population] [Encephale. 2002]

PMID:12091782

Estimating the prevalence of mental disorders in U.S. adults from the Epidemiologic Catchment Area Survey. [Public Health Rep. 1992]

PMID:1454978

1: Br J Psychiatry. 2006 May;188:423-31.

10. Prevalence and correlates of personality disorder in Great Britain.

Coid J, Yang M, Tyrer P, Roberts A, Ullrich S.

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BACKGROUND: Epidemiological data on personality disorders, comorbidity and associated use of services are essential for health service policy. AIMS: To measure the prevalence and correlates of personality disorder in a representative community sample. METHOD: The Structured Clinical Interview for DSM-IVAxis II disorders was used to measure personality disorder in 626 persons aged 16-74 years in households in England,

Scotland and Wales, in a two-phase survey. RESULTS: The weighted prevalence of personality disorder was 4.4% (95% CI 2.9-6.7). Rates were highest among men, separated and unemployed participants in urban locations. High use of healthcare services was confounded by comorbid mental disorder and substance misuse. Cluster B disorders were associated with early institutional care and criminality. CONCLUSIONS: Personality disorder is common in the community, especially in urban areas. Services are normally restricted to symptomatic, help-seeking individuals, but a vulnerable group with cluster B disorders can be identified early, are in care during childhood and enter the criminal justice system when young. This suggests the need for preventive interventions at the public mental health level.

PMID: 16648528 [PubMed - indexed for MEDLINE]

Related Links

Personality and substance use disorders in young adults. [Br J Psychiatry. 2006]

PMID:16582065

Prevalence, correlates, and disability of personality disorders in the United States: results from the national epidemiologic survey on alcohol and related conditions. [J Clin Psychiatry. 2004]

PMID:15291684

Epidemiology, public health and the problem of personality disorder. [Br J Psychiatry Suppl. 2003]

PMID:12509301

Prevalence of DSM-IV disorders and attendant help-seeking in 2 American Indian reservation populations. [Arch Gen Psychiatry. 2005]

PMID:15630077

Lifetime and 12-month prevalence of DSM-III-R psychiatric disorders in the United States. Results from the National Comorbidity Survey. [Arch Gen Psychiatry. 1994]

PMID:8279933

1: Encephale. 2003 Sep-Oct;29(5):391-400.

11. Prevalence of depressive disorders in children and adolescents attending primary care. A survey with the Aquitaine Sentinelle Network.

[Article in French]

Mathet F, Martin-Guehl C, Maurice-Tison S, Bouvard MP.

Centre Hospitalier Charles Perrens 121, rue de la Bechade, 33076 Bordeaux cedex.

Since depressive disorders in children and adolescents have not been widely studied in the context of gene-ral medicine, we conducted an epidemiological survey among general practitioners (GP's) consulted by young subjects aged 7 o 17 years for various reasons. OBJECTIVE: The aims were the following: to estimate the prevalence of depressive disorders in general practice, to detect the eventual existence of particular clinical forms, to assess the frequency of comorbid disorders and to determine to what degree these disorders were diagnosed by GP's. METHOD: The study was conducted over 6 months in concert with 45 practitioners of the Aquitaine Sentinelle Network because of their strong experience in the field of epidemiological surveys, especially regarding psychiatric disorders. The population included all consecutive attenders aged 7 to 17 years. Consent to participate was obtained from children and adolescents and their parents. Finally 155 patients took part. A two-stage epidemiologic strategy was used, including screening tests in the first stage and semi structured interview by clinician in the second stage for diagnostic confirmation. During the first stage, information was obtained from children and adolescents and general practitioners using three questionnaires. The self-report questionnaire Center for Epidemiological Studies Depression (CES-D) was used for screening depression in 13 to 17 years old adolescents and the 20 items of the scale were modified to make it more comprehensible and relevant for children aged 7 to 12. The cut-off of 21 used in France appeared to be the more appropriate in both males and females and was taken to indicate high likelihood of depressive disorder. Therefore people with score 21 or more were approached for the second stage. The Child Behavior Checklist (CBCL), an instrument of well-established validity and reliability, provided information from parents about the child's behavior and competencies. Demographic and environmental data, as well as the reason for the visit and the presence of associated psychological factors were collected from a questionnaire devised for the study and completed by the practitioner. The 21 patients initially detected were invited to take part in the second stage. A total of 18 agreed to meet the psychiatrist.

Sex-ratio female/male of this sample was 1,25 and mean age was 12,5 years. All of them underwent the Schedule for Affective Disorders and Schizophrenia for School Aged Children (Kiddie-SADS), a semi structured research interview of stablished validity. Diagnoses were made according to the DSM IV criteria (American Psychiatric Association). RESULTS: Results showed that more than one child out of 10 aged less than 13 years had a depressive disorder, and that the prevalence in the adolescent sub-group was 5%. Major depressive episode was present in 6% of the children sample, dysthymia in 4% and maladjustment disorder with depressive mood in about 1%. All depressive disorders were moderate. Atypical depression (in the Anglosaxon sense of the term) was present in half of the depressed adolescents. Other disorders included anxiety disorders with a rate of about 4% overanxious in the adolescent sample, obsessive compulsive disorder, panic disorder. Disruptive disorders were considerably less common. Psychiatric comorbidity, usually involving different types of emotional disorders, was present in about 50% of

psychiatric cases, with a prevalence of anxiety disorders. The reasons why depressed subjects consulted were not specific. The most common reasons for visiting the GP were the somatic complaints with a rate of 50% in both populations, whatever the CES-D's score was. A few per cent of patients attending primary care presented with mental health complaints, and the rate was similar in the two populations. Frequency of consultation was not a discriminant factor of depression. Familial cohesion and school performance were not associated with the CES-D's score, nor familial psychiatric history. Personal psychiatric history was related to depression, whereas the occurrence of bereavement made the CES-D score positive but was not significantly associated with fully- blown depression. Finally, we estimated that 70% of diagnoses of depression were not made during the consultation with GP's. CONCLUSION: No particular characteristic of depressed children consulting GP's could be established. These findings underline the importance of training GP's in the screening of depressive disorders in children and adolescents. A better knowledge that young general practice attenders have high rates ofdepressive disorders may facilitate more rapid referral for psychiatric assessment and treatment.

PMID: 14615688 [PubMed - indexed for MEDLINE]

Related Links

[Personality disorders in a nonclinical sample of adolescents] [Encephale. 2002]

PMID:12506264

[Diagnostic structured interviews in child and adolescent's psychiatry] [Encephale. 2004]

PMID:15107714

Children of currently depressed mothers: a STAR*D ancillary study. [J Clin Psychiatry. 2006]

PMID:16426099

[Study on psychiatric disorders and defensive process assessed by the "defense style questionnaire" in sterile males SAMPLE consulting in andrology] [Encephale. 2005]

PMID:16389709

[Study of the CES-D on a sample of 1,953 adolescent students] [Encephale. 2002]

PMID:12386544

1: Arch Gen Psychiatry. 2005 Oct;62(10):1097-106.

Comment in: Evid Based Ment Health. 2006 May;9(2):59.

12. Epidemiology of major depressive disorder: results from the National Epidemiologic Survey on Alcoholism and Related Conditions.

Hasin DS, Goodwin RD, Stinson FS, Grant BF.

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OBJECTIVE: To present nationally representative data on 12-month and lifetime prevalence, correlates, and comorbidity of DSM-IV major depressive disorder (MDD) among adults in the United States. DESIGN/SETTING/ PARTICIPANTS: Face-to-face survey of more than 43 000 adults aged 18 years and older residing in households and group quarters in the United States. MAIN OUTCOME MEASURES: Prevalence and associations of MDD with sociodemographic correlates and Axis I and II disorders. RESULTS: The prevalence of 12-month and lifetime DSM-IV MDD was 5.28% (95% confidence interval, 4.98-5.57) and 13.23% (95% confidence interval, 12.64-13.81), respectively. Being female; Native American; middle-aged; widowed, separated, or divorced; and low income increased risk, and being Asian, Hispanic, or black decreased risk (P<.05). Women were significantly more likely to receive treatment than men. Both current and lifetime MDD were significantly associated with other specific psychiatric disorders, notably substance dependence, panic and generalized anxiety disorder, and several personality disorders. CONCLUSIONS: This large survey suggests a higher prevalence of MDD in the US population than large-sample estimates from the 1980s and 1990s. The shift in highest lifetime risk from young to middle-agedadults is an important transformation in the distribution of MDD in the United States and specificity in risk for an age-period cohort. Associations between MDD and Axis I and II disorders were strong and significant, with variation within broad categories by specific diagnoses signaling the need for attention to the genetic and environmental reasons for such variation, as well as theimplications for treatment response.

PMID: 16203955 [PubMed - indexed for MEDLINE]

Related Links

The epidemiology of social anxiety disorder in the United States: results from the National Epidemiologic Survey on Alcohol and Related Conditions. [J Clin Psychiatry. 2005]

PMID:16420070

Comorbidity of DSM-IV pathological gambling and other psychiatric disorders: results from the National Epidemiologic Survey on Alcohol and Related Conditions. [J Clin Psychiatry. 2005]

PMID:15889941

Prevalence, correlates, and comorbidity of bipolar I disorder and axis I and II disorders: results from the National Epidemiologic Survey on Alcohol and Related Conditions. [J Clin Psychiatry. 2005]

PMID:16259532

The epidemiology of DSM-IV panic disorder and agoraphobia in the United States: results from the National Epidemiologic Survey on Alcohol and Related Conditions. [J Clin Psychiatry. 2006]

PMID:16649821

The epidemiology of major depressive disorder: results from the National Comorbidity Survey Replication (NCS-R). [JAMA. 2003]

PMID:12813115

1: Encephale. 2005 Mar-Apr;31(2):182-94.

13. Prevalence and comorbidity of psychiatric disorders in the French general population.

[Article in French]

Lepine JP, Gasquet I, Kovess V, Arbabzadeh-Bouchez S, Negre-Pages L, Nachbaur G, Gaudin AF.

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INTRODUCTION: ESEMeD is the first international epidemiological study using a random sampling method that has allowed the prevalence of psychiatric disorders in France to be measured with precision and compared directly with that observed in other European countries. OBJECTIVES: 1) To determine the 12 month and lifetime prevalence of mood -disorders, anxiety disorders and alcohol-related disorders. 2) To estimate the comorbidity between these disorders. 3) To evaluate potential demographic risk factors for these disorders. METHODS: This was a transversal survey carried out between 2001 and 2003 of non-institutionalised subjects aged 18 or over in the general population of Germany (n = 3,555), Belgium (n = 2,419), Spain (n = 5,473), France (n = 2,894), the Netherlands (n = 2,372) and Italy (n = 4,712). In France, the sampling source was a randomly generated list of telephone numbers. Subjects were interviewed at home by professional interviewers. The WMH-CIDI questionnaire was used. RESULTS: The participation rate was 46% for France and 61% for all six countries combined. The 12 month and lifetime prevalence rates observed were respectively 6.0% and 21,4% for major depressive episodes, 1.6% and 7.9% for dysthymia, 2.1% and 6.0% for the generalised -anxiety disorders, 1.2% and 3.0% for panic disorders, 0.6% and 1.8% for agoraphobia, 2.2% and 3.9% for post-traumatic stress disorder, 1.7% and 4.7% for social phobia, 4.7% and

11,6% for specific phobia, 0.5% and 4.1% for alcohol abuse and 0.3% and 1.6% for alcohol dependence.Mood disorders and anxiety disorders were significantly more frequent in women, whilst alcohol-related disorders were more frequent in men. The prevalence of all three types of disorder was lower in elderly subjects and in those living in a rural environment. Mood disorders and alcohol-related disorders were more frequent in individuals living alone and mood disorders more frequent in those without paid employment. 38% of subjects with mood disorder also presented an anxiety disorder or an alcohol-related disorder. The comorbidity of mood and anxiety disorders was more frequent in women, younger subjects and those living alone. The comorbidity rate in subjects with anxiety disorders was 26% and did not differ between genders. For alcohol-related disorders, there was a striking difference in comorbidity rate between men and women: 26% in the former and 67% in the latter. CONCLUSION: This study underlines the high prevalence of mood disorders, anxiety disorders and alcohol-related disorders in France and demonstrates a high degree of comorbidity between them. For this reason, it is important to evaluate and take into account potential comorbidity in the management of individuals with psychiatric disorders.

PMID: 15959445 [PubMed - indexed for MEDLINE]

Related Links

[Psychotropic drug use and mental psychiatric disorders in France; results of the general population ESEMeD/MHEDEA 2000 epidemiological study] Encephale. 2005]

PMID:15959446

12-Month comorbidity patterns and associated factors in Europe: results from the European Study of the Epidemiology of Mental Disorders (ESEMeD) project. [Acta Psychiatr Scand Suppl. 2004]

PMID:15128385

Prevalence of mental disorders in Europe: results from the European Study of the Epidemiology of Mental Disorders (ESEMeD) project. [Acta Psychiatr Scand Suppl. 2004]

PMID:15128384

Prevalence of common mental disorders in Italy : Results from the European Study of the Epidemiology of Mental Disorders (ESEMeD). [Soc Psychiatry Psychiatr Epidemiol. 2006]

PMID:16915360

[A connection between insomnia and psychiatric disorders in the French general population] [Encephale. 2002]

PMID:12386543

1: J Stud Alcohol. 2005 Mar;66(2):246-53.

14. Psychiatric disorders among at-risk consumers of alcohol in the general population.

Bott K, Meyer C, Rumpf HJ, Hapke U, John U.

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OBJECTIVE: At-risk consumption of alcohol has increasingly become the focus of primary and secondary prevention efforts. Little is known about the co-occurrence of psychiatric disorders with at-risk drinking. We examinedpatterns of Diagnostic and Statistical Manual of Mental Disorders, FourthEdition, (DSM-IV) lifetime co-occurrence of psychiatric disorders in individualsin the general population with at-risk consumption of alcohol, alcohol abuse,alcohol dependence and moderate drinking/abstention, considering potentialgender differences. METHOD: Cross-sectional data of a representative generalpopulation-based study were analyzed. Based on DSM-IV criteria, participants aged 18-64 (N = 4,074; 2,045 men) were diagnosed using a standardized computer-assisted version of the Munich Composite International Diagnostic Interview (M-CIDI). Nonpsychotic Axis-I lifetime diagnoses were examined. At-risk consumption of alcohol was defined as an average of more than 20 g (0.71 oz) pure alcohol consumption per day for women and 30 g (1.06 oz) for men, with alcohol abuse or alcohol dependence excluded. RESULTS: Almost 9% of participants were identified as at-risk drinkers. Prevalence rates for at-risk drinkers were 16.9% for affective, 18.1% for anxiety and 17.8% for somatoform disorders. Compared with moderate drinkers/abstainers, at-risk drinkers showed a twofold increased risk of having a psychiatric disorder. Subjects with alcohol abuse showed a comparable level of risk and individuals with alcohol dependence showed an even greater risk. Female at-risk drinkers were twice as likely to have a psychiatric disorder as their male counterparts. The odds ratios for psychiatric disorders in at-risk drinkers compared with moderate drinkers/abstainers, however, did not differ in men and women. CONCLUSIONS: Rates of psychiatric co-occurrence among at-risk drinkers were considerably elevated when compared with moderate drinkers/abstainers. These findings underline the relevance of at-risk consumption of alcohol and represent an important challenge to public health efforts regarding screening of psychiatric disorders and referral to appropriate treatment services.

PMID: 15957676 [PubMed - indexed for MEDLINE]

Related Links

Does a U-shaped relationship exist between alcohol use and DSM-III-R mood and anxiety disorders? [J Affect Disord. 2004]

PMID:15465583

Epidemiology of psychiatric and alcohol disorders in Ukraine: findings from the Ukraine World Mental Health survey. [Soc Psychiatry Psychiatr Epidemiol. 2005]

PMID:16160752

Prevalence of DSM-IV disorders and attendant help-seeking in 2 American Indian reservation populations. [Arch Gen Psychiatry. 2005] PMID:15630077

[Prevalence and comorbidity of psychiatric disorders in the French general population] [Encephale. 2005]

PMID:15959445

The co-occurrence of DSM-IV alcohol abuse in DSM-IV alcohol dependence: results of the National Epidemiologic Survey on Alcohol and Related Conditions on heterogeneity that differ by population subgroup. [Arch Gen Psychiatry. 2004]

PMID:15351767

1: J Clin Psychiatry. 2004 Jul;65(7):948-58.

15. Prevalence, correlates, and disability of personality disorders in the United States: results from the national epidemiologic survey on alcohol and related conditions.

Grant BF, Hasin DS, Stinson FS, Dawson DA, Chou SP, Ruan WJ, Pickering RP.

Division of Intramural Clinical and Biological Research, National Institute on Alcohol Abuse and Alcoholism, National Institutes of Health, U.S. Department of Health and Human Services, Bethesda, MD 20892-9304, USA. bgrant@willco.niaaa.nih.gov

OBJECTIVE: To present nationally representative data on the prevalence, sociodemographic correlates, and disability of 7 of the 10 DSM-IV personality disorders. METHOD: The data were derived from the 2001-2002 National Epidemiologic Survey on Alcohol and Related Conditions (N = 43,093). Diagnoses were made using the Alcohol Use Disorder and Associated Disabilities Interview Schedule-DSM-IV Version, and associations between personality disorders and sociodemographic correlates were determined. The relationship between personality disorders and 3 emotional disability scores (Short-Form 12, version 2) was also examined. RESULTS: Overall, 14.79% of adult Americans (95% CI = 14.08 to 15.50), or 30.8 million, had at least 1 personality disorder. The most prevalent personality disorder in the general population was obsessive-compulsive personality disorder, 7.88% (95% CI = 7.43 to 8.33), followed by paranoid personality disorder 4.41% (95% CI = 4.12 to 4.70), antisocial personality disorder 3.63% (95% CI = 3.34 to 3.92), schizoid personality disorder 3.13% (95% CI = 2.89 to 3.37), avoidant

personality disorder 2.36% (95% CI = 2.14 to 2.58), histrionic personality disorder 1.84% (95% CI = 1.66 to 2.02), and dependent personality disorder 0.49% (95% CI = 0.40 to 0.58). The risk of avoidant, dependent, and paranoid personality disorders was significantly greater among women than men ($p < .05$); the risk of antisocial personality disorder was greater among men compared with women ($p < .05$); and no sex differences were observed in the risk of obsessive-compulsive, schizoid, or histrionic personality disorders. In general, risk factors for personality disorders included being Native American or black, being a young adult, having low socioeconomic status, and being divorced, separated, widowed, or never married. Avoidant, dependent, schizoid, paranoid, and antisocial personality disorders ($p < .02$ to $p < .0001$) were each statistically significant predictors of disability. Obsessive-compulsive personality disorder was inconsistently related to disability. In contrast, disability was not significantly different among individuals with histrionic personality disorder compared with those without the disorder. CONCLUSION: Personality disorders are prevalent in the general population and are generally highly associated with disability. This study highlights the need to develop more effective and targeted prevention and intervention initiatives for personality disorders.

PMID: 15291684 [PubMed - indexed for MEDLINE]

Related Links

Prevalence, correlates, and comorbidity of DSM-IV antisocial personality syndromes and alcohol and specific drug use disorders in the United States: results from the national epidemiologic survey on alcohol and related conditions. [J Clin Psychiatry. 2005]

PMID:15960559

Prevalence, correlates, and comorbidity of bipolar I disorder and axis I and II disorders: results from the National Epidemiologic Survey on Alcohol and Related Conditions. [J Clin Psychiatry. 2005]

PMID:16259532

Comorbidity of DSM-IV pathological gambling and other psychiatric disorders: results from the National Epidemiologic Survey on Alcohol and Related

Conditions. [J Clin Psychiatry. 2005]

PMID:15889941

Co-occurrence of 12-month alcohol and drug use disorders and personality disorders in the United States: results from the National Epidemiologic Survey on Alcohol and Related Conditions. [Arch Gen Psychiatry. 2004]

PMID:15066894

[Personality disorders in a nonclinical sample of adolescents] [Encephale.

2002]

PMID:12506264

1: Biol Psychiatry. 1999 Feb 1;45(3):300-7.

16. The prevalence of depressive disorders in the United Kingdom.

Ohayon MM, Priest RG, Guilleminault C, Caulet M.

Centre de Recherche Philippe Pinel de Montreal, Quebec, Canada.

BACKGROUND: The prevalence of major psychiatric disorders in the general population is difficult to pinpoint owing to widely divergent estimates yielded by studies employing different criteria, methods, and instruments. Depressive disorders, which represent a sizable mental health care expense for the public purse, are no exception to the rule. METHODS: The prevalence of depressive disorders was assessed in a representative sample (n = 4972) of the U.K. general population in 1994. Interviews were performed over the telephone by lay interviewers using an expert system that tailored the questionnaire to each individual based on prior responses. Diagnoses and symptoms lists were based on the DSM-IV. RESULTS: Five percent (95% confidence interval = 4.4-5.6%) of the sample was diagnosed by the system with a depressive disorder at the time of the interview, with the rate slightly higher for women (5.9%) than men (4.2%). Unemployed, separated, divorced, and widowed individuals were found to be at higher risk for depression. Depressive subjects were seen almost exclusively by general practitioners (only 3.4% by psychiatrists). Only 12.5% of them consulted their physician seeking mental health treatment, and 15.9% reported being hospitalized in the past 12 months. CONCLUSIONS: The study indicates that mental health problems in the community are seriously underdetected by general practitioners, and that these professionals are highly reluctant to refer patients with depressive disorders to the appropriate specialist.

PMID: 10023506 [PubMed - indexed for MEDLINE]

Related Links

[A connection between insomnia and psychiatric disorders in the French

general population] [Encephale. 2002]

PMID:12386543

[Prevalence of depressive disorders in children and adolescents attending primary care. A survey with the Aquitaine Sentinelle Network] [Encephale. 2003]

PMID:14615688

Prevalence of major depressive disorder in the general population of South Korea. [J Psychiatr Res. 2006]

PMID:15878179

Using chronic pain to predict depressive morbidity in the general population. [Arch Gen Psychiatry. 2003]

PMID:12511171

[Personality disorders in a nonclinical sample of adolescents] [Encephale. 2002]

PMID:12506264

1: Arch Gen Psychiatry. 2003 Feb;60(2):184-9.

17. Screening for serious mental illness in the general population.

Kessler RC, Barker PR, Colpe LJ, Epstein JF, Gfroerer JC, Hiripi E, Howes MJ, Normand SL, Manderscheid RW, Walters EE, Zaslavsky AM.

Department of Health Care Policy, Harvard Medical School, 180 Longwood Ave, Suite 215, Boston, MA 02115, USA. kessler@hcp.med.harvard.edu

BACKGROUND: Public Law 102-321 established a block grant for adults with "serious mental illness" (SMI) and required the Substance Abuse and Mental Health Services Administration (SAMHSA) to develop a method to estimate the prevalence of SMI. METHODS: Three SMI screening scales were developed for possible use in the SAMHSA National Household Survey on Drug Abuse: the Composite International Diagnostic Interview Short-Form (CIDI-SF) scale, the K10/K6 nonspecific distress scales, and the World Health Organization disability Assessment Schedule (WHO-DAS). An enriched convenience sample of 155 respondents was administered all screening scales followed by the 12-month Structured Clinical Interview for DSM-IV and the Global Assessment of Functioning (GAF). We defined SMI as any 12-month DSM-IV disorder, other than a substance use disorder, with a GAF score of less than 60. RESULTS: All screening scales were significantly related to SMI. However, neither the CIDI-SF nor the WHO-DASimproved prediction significantly over the K10 or K6 scales. The area under the receiver operating characteristic curve of SMI was 0.854 for K10 and 0.865 for K6. The most efficient screening scale, K6, had a sensitivity (SE) of 0.36 (0.08) and a specificity of 0.96 (0.02) in predicting SMI. CONCLUSIONS: The brevity and accuracy of the K6 and K10 scales make them attractive screens for SMI. Routine inclusion of either scale in clinical studies would create an important, and heretofore missing, crosswalk between community and clinical epidemiology.

PMID: 12578436 [PubMed - indexed for MEDLINE]

Related Links

Short screening scales to monitor population prevalences and trends in non-specific psychological distress. [Psychol Med. 2002]

PMID:12214795

The performance of the K6 and K10 screening scales for psychological distress in the Australian National Survey of Mental Health and Well-Being. [Psychol Med. 2003]

PMID:12622315

Challenges in operationalizing the DSM-IV clinical significance criterion. [Arch Gen Psychiatry. 2004]

PMID:15583111

Short screening scale for DSM-IV posttraumatic stress disorder. [Am J Psychiatry. 1999]

PMID:10360131

Prevalence, severity, and comorbidity of 12-month DSM-IV disorders in the National Comorbidity Survey Replication. [Arch Gen Psychiatry. 2005]

PMID:15939839

1: Psychol Med. 2002 Aug;32(6):959-76.

18. Short screening scales to monitor population prevalences and trends in non-specific psychological distress.

Kessler RC, Andrews G, Colpe LJ, Hiripi E, Mroczek DK, Normand SL, Walters EE, Zaslavsky AM.

Department of Health Care Policy, Harvard Medical School, Boston, MA 02115, USA.

BACKGROUND: A 10-question screening scale of psychological distress and a six-question short-form scale embedded within the 10-question scale were developed for the redesigned US National Health Interview Survey (NHIS).

METHODS: Initial pilot questions were administered in a US national mail survey (N = 1401). A reduced set of questions was subsequently administered in a US national telephone survey (N = 1574). The 10-question and six-question scales, which we refer to as the K10 and K6, were constructed from the reduced set of questions based on Item Response Theory models. The scales were subsequently validated in a two-stage clinical reappraisal survey (N = 1000 telephone screening interviews in the first stage followed by N = 153 face-to-face clinical interviews in the second stage that oversampled first-stage respondents who screened positive for emotional problems) in a local convenience sample. The second-stage sample was administered the screening scales along with the Structured Clinical Interview for DSM-IV (SCID). The K6 was subsequently included in the 1997 (N = 36116) and 1998 (N = 32440) US National Health Interview Survey, while the K10 was included in the 1997 (N = 10641) Australian National Survey of Mental Health and Well-Being. RESULTS: Both the K10 and K6 have good precision in the 90th-99th percentile range of the population distribution (standard errors of standardized scores in the range 0.20-0.25) as well as consistent psychometric properties across major sociodemographic subsamples. The scales strongly discriminate between community cases and non-cases of

DSM-IV/SCID disorders, with areas under the Receiver Operating Characteristic (ROC) curve of 0.87-0.88 for disorders having Global Assessment of Functioning (GAF) scores of 0-70 and 0.95-0.96 for disorders having GAF scores of 0-50. CONCLUSIONS: The brevity, strong psychometric properties, and ability to discriminate DSM-IV cases from non-cases make the K10 and K6 attractive for use in general-purpose health surveys. The scales are already being used in annual government health surveys in the US and Canada as well as in the WHO World Mental Health Surveys. Routine inclusion of either the K10 or K6 in clinical studies would create an important, and heretofore missing, crosswalk between community and clinical epidemiology.

PMID: 12214795 [PubMed - indexed for MEDLINE]

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Screening for serious mental illness in the general population. [Arch Gen Psychiatry. 2003]

PMID:12578436

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PMID:12622315

Validation study of a nonspecific psychological distress scale. [Soc Psychiatry Psychiatr Epidemiol. 2005]

PMID:16215656

[Methodology of a study on insomnia in the general population] [Encephale. 2002]

PMID:12091782

[Diagnostic structured interviews in child and adolescent's psychiatry] [Encephale. 2004]

PMID:15107714

1: Ment Health Serv Res. 2004 Mar;6(1):33-46.

19. Assessing population need for mental health care: a review of approaches and predictors.

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This review aimed to clarify the concept of need, explore the different approaches used to assess need, and contribute to an improved

understanding of predictor and intervening factors in assessing need for mental health services.

Two population-based needs assessment approaches have been identified: modeling need for services and surveys of the general population. The most widely used model was that based on the Jarman-8 index of social deprivation. The population-based epidemiological surveys addressed perceived need by seeking direct, self-reported measures of individuals' perceptions of their needs for care. Although many studies have reported correlates of service use, few have attempted to identify correlates of perceived need. The fact that two-thirds to three-quarters of people were identified as meeting criteria for a mental health disorder, but did not report receiving treatment, highlighted a gap between epidemiology and service use. This gap could be explained by a number of intervening factors such as the discordance between diagnosis and disability, the determinants of and barriers to help-seeking behavior, the belief systems concerning appropriate treatments, and choice of health professionals. This review has thus identified the predictor variables which are important for a comprehensive analysis of need for mental health care. Suggestions and challenges have been put forward to address the identified gaps in assessing population need.

PMID: 15002679 [PubMed - indexed for MEDLINE]

Related Links

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PMID:16276856

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PMID:12745332

Epidemiology and health service resource allocation policy for alcohol, drug abuse, and mental disorders. [Public Health Rep. 1984]

PMID:643516

1: Aust N Z J Psychiatry. 2004 Aug;38(8):635-8.

20. Is the Australian National Survey of Mental Health and Wellbeing a reliable guide for health planners? A methodological note on the prevalence of depression.

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OBJECTIVE: To consider whether the prevalence of depression reported in the Australian National Survey of Mental Health and Wellbeing is a reliable guide for mental health planners. METHOD: A comparison of methodologies for the detection of depression in the Australian National Survey and a South Australian survey. RESULTS: The Australian National Survey using the Composite International Diagnostic Interview (CIDI) reported considerably less depression than a South Australian survey, which used the mood module of the PRIME-MD 1000 study. Although the PRIME-MD may over-diagnose depression, it is probable that the preclusion criteria of the CIDI result in an under-reporting of depression.

CONCLUSIONS: It is probable that the Australian National Survey under-estimates the prevalence of depression in the community. This has implications not only in assessing the morbidity and economic burden of depression, but also for the planning of future mental health services.

PMID: 15298586 [PubMed - indexed for MEDLINE]

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PMID:12798255

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PMID:9375257

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PMID:12780477

Psychiatry and the need for mental health care in Australia: findings from the National Survey of Mental Health and Wellbeing. [Aust N Z J Psychiatry.

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PMID:11982542

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PMID:16866757

1: Psychol Med. 2001 Jul;31(5):769-77.

21. Non-disabled cases in a national survey.

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BACKGROUND: Lifetime and 12-month prevalence estimates of mental disorders consistently reported in large-scale community surveys have met with deserved scepticism. A crucial variable is the extent to which people who are considered cases are also disabled by their symptoms. In a national population survey, we hypothesized that an administratively significant proportion of persons with anxiety or depressive disorders according to ICD-10 and DSM-IV would report no disability. METHODS: Interviews were sought on a nationally representative sample of people aged 18 and over across Australia. The Composite International Diagnostic Interview on laptop (CIDI-A) was used by professional survey interviewers to identify persons meeting ICD-10 or DSM-IV criteria for anxiety or depressive disorders in the previous 4 weeks, together with self-reported data on associated disability and medical consultations for the same period.

RESULTS: In an achieved sample of 10,641 persons (response rate = 78%), no disability in daily life was reported by 28% of persons with an anxiety isorder and 15% with a depressive disorder by ICD-10 criteria; and by 20.4% and 13.9% respectively by DSM-IV. Non-disabled respondents had lower scores on two measures of psychological distress and markedly lower rates for having consulted a doctor for their symptoms. CONCLUSION: The ICD-10 and DSM-IV criteria for anxiety and depressive disorders, when applied to the information on symptoms elicited by the CIDI-A, inadequately discriminate between people who are and are not disabled by their symptoms. There may be a group of highly symptomatic people in the general population who tolerate their symptoms and are not disabled by them.

PMID: 11459375 [PubMed - indexed for MEDLINE]

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PMID:11556437

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PMID:8179459

1: Arch Gen Psychiatry. 2005 Oct;62(10):1097-106.

Comment in: Evid Based Ment Health. 2006 May;9(2):59.

22. Epidemiology of major depressive disorder: results from the National Epidemiologic Survey on Alcoholism and Related Conditions.

Hasin DS, Goodwin RD, Stinson FS, Grant BF.

Mailman School of Public Health, Division of Epidemiology and College of Physicians and Surgeons, Department of Psychiatry, Columbia University, New York, NY, USA.

OBJECTIVE: To present nationally representative data on 12-month and lifetime prevalence, correlates, and comorbidity of DSM-IV major depressive disorder (MDD) among adults in the United States. DESIGN/SETTING/ PARTICIPANTS: Face-to-face survey of more than 43 000 adults aged 18 years and older residing in households and group quarters in the United States. MAIN OUTCOME MEASURES: Prevalence and associations of MDD with sociodemographic correlates and Axis I and II disorders. RESULTS: The prevalence of 12-month and lifetime DSM-IV MDD was 5.28% (95% confidence interval, 4.98-5.57) and 13.23% (95% confidence interval, 12.64-13.81), respectively. Being female; Native American; middle-aged; widowed, separated, or divorced; and low income increased risk, and being Asian, Hispanic, or black decreased risk (P<.05). Women were significantly more likely to receive treatment than men. Both current and lifetime MDD were significantly associated with other specific psychiatric disorders, notably substance dependence, panic and generalized anxiety disorder, and several personality disorders. CONCLUSIONS: This large survey suggests a higher prevalence of MDD in the US population than large-sample estimates from the 1980s and 1990s. The shift in highest lifetime risk from young to middle-aged adults is an important transformation in the distribution of MDD in the United States and specificity in risk for an age-period cohort. Associations

between MDD and Axis I and II disorders were strong and significant, with variation within broad categories by specific diagnoses signaling the need for attention to the genetic and environmental reasons for such variation, as well as the implications for treatment response.

PMID: 16203955 [PubMed - indexed for MEDLINE]

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The epidemiology of social anxiety disorder in the United States: results from the National Epidemiologic Survey on Alcohol and Related Conditions. [J Clin Psychiatry. 2005]

PMID:16420070

Comorbidity of DSM-IV pathological gambling and other psychiatric disorders: results from the National Epidemiologic Survey on Alcohol and Related Conditions. [J Clin Psychiatry. 2005]

PMID:15889941

Prevalence, correlates, and comorbidity of bipolar I disorder and axis I and II disorders: results from the National Epidemiologic Survey on Alcohol and Related Conditions. [J Clin Psychiatry. 2005]

PMID:16259532

The epidemiology of DSM-IV panic disorder and agoraphobia in the United States: results from the National Epidemiologic Survey on Alcohol and Related Conditions. [J Clin Psychiatry. 2006]

PMID:16649821

The epidemiology of major depressive disorder: results from the National Comorbidity Survey Replication (NCS-R). [JAMA. 2003]

PMID:12813115

23. Prevalence and Treatment of Mental Disorders, 1990 to 2003.

Ronald C. Kessler, Ph.D., Olga Demler, M.A., M.S., Richard G. Frank, Ph.D., Mark Olfson, M.D., Harold Alan Pincus, M.D., Ellen E. Walters, M.S.,Philip Wang, M.D., Dr.P.H., Kenneth B. Wells, M.D., and Alan M. Zaslavsky, Ph.D.

Background: Although the 1990s saw enormous change in the mental health care system in the United States, little is known about changes in the prevalence or rate of treatment of mental disorders.

Methods: We examined trends in the prevalence and rate of treatment of mental disorders among people 18 to 54 years of age during roughly the past decade. Data from the National Comorbidity Survey (NCS) were obtained in 5388 face-to-face household interviews conducted between 1990 and 1992, and data from the NCS Replication were obtained in 4319

interviews conducted between 2001 and 2003. Anxiety disorders, mood disorders, and substance-abuse disorders that were present during the 12 months before the interview were diagnosed with the use of the American Psychiatric Association's

Diagnostic and Statistical Manual of Mental Disorders, fourth edition (DSM-IV). Treatment for emotional disorders was categorized according to the sector of mental health services: psychiatry services, other mental health services, general medical services, human services, and complementary–alternative medical services.

Results: The prevalence of mental disorders did not change during the decade (29.4 percent between 1990 and 1992 and 30.5 percent between 2001 and 2003, P=0.52), but the rate of treatment increased. Among patients with a disorder, 20.3 percent received treatment between 1990 and 1992 and 32.9 percent received treatment between 2001 and 2003 (P<0.001). Overall, 12.2 percent of the population 18 to 54 years of age received treatment for emotional disorders between 1990 and 1992 and 20.1 percent between 2001 and 2003 (P<0.001). Only about half those who received treatment had disorders that met diagnostic criteria for a mental disorder. Significant increases in the rate of treatment (49.0 percent between 1990 and 1992 and 49.9 percent between 2001 and 2003) were limited to the sectors of general medical services (2.59 times as high in 2001 to 2003 as in 1990 to 1992), psychiatry services (2.17 times as high), and other mental health services (1.59 times as high) and were independent of the severity of the disorder and of the sociodemographic characteristics of the respondents.

Conclusions: Despite an increase in the rate of treatment, most patients with a mental disorder did not receive treatment. Continued efforts are needed to obtain data on the effectiveness of treatment in order to increase the use of effective treatments.

1: Am J Psychiatry. 1999 Jun;156(6):928-34.

24. Gaps in service utilization by Mexican Americans with mental health problems.

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OBJECTIVE: The purpose of this study was to ascertain the degree of underutilization of services for mental health problems among urban and rural Mexican American adults. METHOD: A probability sample (N = 3,012) was sed to represent the Mexican American population of Fresno County, California, and face-to-face interviews were conducted with the use of the Composite International Diagnostic Interview. Bivariate and multivariate analyses were used to analyze the data on diagnosis and service utilization. RESULTS: Among the respondents with DSM-III-R-defined disorders, only about one-fourth had used a single service or a

combination of services in the past 12 months, and Mexican immigrants had a utilization rate which was only two-fifths of that of Mexican Americans born in the United States. Overall use of mental health care providers by persons with diagnosed mental disorders was 8.8%, use of providers in the general medical sector was 18.4%, use of other professionals was 12.7%, and use of informal providers was only 3.1%. According to logistic regression analyses, factors associated with utilization of mental health services included female sex, higher educational attainment, unemployment, and comorbidity.

CONCLUSIONS: Immigrants are unlikely to use mental health services, even when they have a recent disorder, but may use general practitioners, which raises questions about the appropriateness, accessibility, and cost-effectiveness of mental health care for this population. Several competing hypotheses about the reasons for low utilization of services need to be examined in future research.

PMID: 10360134 [PubMed - indexed for MEDLINE]

Related Links

Lifetime prevalence of DSM-III-R psychiatric disorders among urban and rural Mexican Americans in California. [Arch Gen Psychiatry. 1998]

PMID:9736002

Help seeking by persons of Mexican origin with functional impairments. [Psychiatr Serv. 2000]

PMID:11013330

Utilization of health and mental health services by Los Angeles Mexican Americans and non-Hispanic whites. [Arch Gen Psychiatry. 1987] PMID:3632245

Prevalence of mental disorders and utilization of mental health services in two American Indian reservation populations: mental health disparities in a national context. [Am J Psychiatry. 2005]

PMID:16135633

A community survey of psychological impairment among Anglo- and Mexican Americans and its relationship to service utilization. [Community Ment Health J. 1985]

PMID:3995900

1: Psychol Med. 2005 Dec;35(12):1773-83.

25. Prevalence, service use, and demographic correlates of 12-month DSM-IV psychiatric disorders in Mexico: results from the Mexican National Comorbidity Survey.

Medina-Mora ME, Borges G, Lara C, Benjet C, Blanco J, Fleiz C, Villatoro J, Rojas E, Zambrano J.

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BACKGROUND: This paper describes the 12-month prevalence, severity and demographic correlates of 16 DSM-IV psychiatric disorders and service utilization in the Mexican urban population aged 18-65 years of age. This is representative of 75% of the national adult population. METHOD: The sample design was a strict probability selection scheme. The response rate was 76.6%. The World Mental Health Survey version of the Composite International Diagnostic Interview was installed on laptops and administered by lay interviewers. An international WHO task force carried out its translation into Spanish.

RESULTS: The 12-month prevalence of any disorder was 12.1%. The most common disorders were specific phobia (4.0%), major depressive disorder (3.7%) and alcohol abuse or dependence (2.2%). The 12-month prevalence of very severe disorders was 3.7% of which only 24% used any services. Age was the only variable associated with any 12-month disorder, with the younger more likely to report any disorder. Income was associated with severity, with low and low-average incomes more likely to report a 12-month disorder. Females were more likely to report a mood and anxiety disorder, but less likely to report a substance disorder. The group of separated/widowed/divorced was more likely to report a mood and an impulse-control disorder. CONCLUSIONS: The results show that while psychiatric disorders are common in the Mexican population, very severe mental disorders are less common and there is extreme under-utilization of mental health services.

PMID: 16300691 [PubMed - indexed for MEDLINE]

Related Links

Lifetime and 12-month prevalence of DSM-III-R psychiatric disorders in the United States. Results from the National Comorbidity Survey. [Arch Gen Psychiatry. 1994]

PMID:8279933

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Population prevalence of psychiatric disorders in Chile: 6-month and 1-month rates. [Br J Psychiatry. 2004]

PMID:15056573

1: Arch Gen Psychiatry. 2004 Jan;61(1):85-93.

26. The DSM-IV rates of child and adolescent disorders in Puerto Rico: prevalence, correlates, service use, and the effects of impairment.

Canino G, Shrout PE, Rubio-Stipec M, Bird HR, Bravo M, Ramirez R, Chavez L, Alegria M, Bauermeister JJ, Hohmann A, Ribera J, Garcia P, Martinez-Taboas A.

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BACKGROUND: Few prevalence studies in which DSM-IV criteria were used in children in representative community samples have been reported. We present prevalence data for the child and adolescent population of Puerto Rico and examine the relation of DSM-IV diagnoses to global impairment, demographic correlates, and service use in an island-wide representative sample. METHODS: We sampled 1886 child-caretaker dyads in Puerto Rico by using a multistage sampling design. Children were aged 4 to 17 years. Response rate was 90.1%. Face-to-face interviews of children and their primary caretakers were performed by trained laypersons who administered the Diagnostic Interview Schedule for Children, version IV (DISC-IV) in Spanish. Global impairment was measured by using the Children's Global Assessment Scale scored by the interviewer of the parent. Reports of service use were obtained by using the Service Assessment for Children and Adolescents. RESULTS: Although 19.8% of the sample met DSM-IV criteria without considering impairment, 16.4% of the population had 1 or more of the DSM-IV disorders when a measure of impairment specific to each diagnosis was considered. The overall prevalence was further reduced to 6.9% when a measure of global impairment was added to that definition. The most prevalent disorders were attention-deficit/hyperactivity disorder (8.0%) and oppositional defiant disorder (5.5%). Children in urban settings had higher rates than those in rural regions. Older age was related to higher rates of major depression and social phobia, and younger age was related to higher rates of attention-deficit/hyperactivity disorder. Both overall rates and rates of specific DSM-IV/DISC-IV disorders were related to service use. Children

with impairment without diagnosis were more likely to use school services, whereas children with impairment with diagnosis were more likely to use the specialty mental health sector. Of those with both a diagnosis and global impairment, only half received services from any source. CONCLUSIONS: Because we used the DISC-IV to apply DSM-IV criteria, the study yielded prevalence rates that are generally comparable with those found in previous surveys. The inclusion of diagnosis-specific impairment criteria reduced rates slightly. When global impairment criteria were imposed, the rates were reduced by approximately half.

PMID: 14706947 [PubMed - indexed for MEDLINE]

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PMID:16313431

[Diagnostic structured interviews in child and adolescent's psychiatry] [Encephale. 2004]

PMID:15107714

Rates of DSM-IV psychiatric disorders among adolescents in a large metropolitan area. [J Psychiatr Res. 2006]

PMID:17107689

[Personality disorders in a nonclinical sample of adolescents] [Encephale.

2002]

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Examining minor and major depression in adolescents. [J Child Psychol Psychiatry. 2005]

PMID:16033637

27. Los trastornos mentales en América Latina y el Caribe: asunto prioritario para la salud pública

Robert Kohn,1 Itzhak Levav,2 José Miguel Caldas de Almeida,3 Benjamín Vicente,4 Laura Andrade,5 Jorge J. Caraveo-Anduaga,6 Shekhar Saxena7 y Benedetto Saraceno7

OBJETIVO: La creciente carga de trastornos mentales que afecta a las poblaciones de América Latina y el Caribe es demasiado grande para hacer caso omiso de ella. Por lo tanto, es una necesidad impostergable conocer la prevalencia de los trastornos mentales y la brecha de tratamiento, que está dada por la diferencia entre las tasas de prevalencia verdadera y las de las personas que han sido tratadas, que en algunos casos es grande pese a la existencia de tratamientos eficaces. Si se dispone de mayor informacion, se hace más factible 1) abogar mejor por los intereses de las personas que necesitan atención, 2) adoptar políticas

más eficaces, 3) formular programas de intervención innovadores y 4) adjudicar recursos en conformidad con las necesidades observadas.

MÉTODOS: Los datos se obtuvieron de estudios comunitarios publicados en América Latina y el Caribe entre 1980 y 2004. En esas investigaciones epidemiológicas se usaron instrumentos diagnósticos estructurados y se estimaron tasas de prevalencia. Las tasas brutas de diversos trastornos psiquiátricos en América Latina y el Caribe se estimaron a partir de las tasas media y mediana extraídas de los estudios, desglosadas por sexo. También se extrajeron los datos correspondientes al uso de servicios de salud mental para poder calcular la brecha en el tratamiento según trastornos específicos.

RESULTADOS: Las psicosis no afectivas (entre ellas la esquizofrenia) tuvieron una prevalencia media estimada durante el año precedente de 1,0%; la depresión mayor, de 4,9%; y el abuso o la dependencia del alcohol, de 5,7%. Más de la tercera parte de las personas afectadas por psicosis no afectivas, más de la mitad de las afectadas por trastornos de ansiedad, y cerca de tres cuartas partes de las que abusaban o dependían del alcohol no habían recibido tratamiento psiquiátrico alguno, sea en un servicio especializado o en uno de tipo general.

CONCLUSIONES: La actual brecha en el tratamiento de los trastornos mentales en América Latina y el Caribe sigue siendo abrumadora. Además, las tasas actuales probablemente subestiman el número de personas sin atención. La transición epidemiológica y los cambios en la composición poblacional acentuarán aun más la brecha en la atención en América Latina y el Caribe, a no ser que se formulen nuevas políticas de salud mental o que se actualicen las existentes, procurando incluir en ellas la extensión de los programas y servicios.

28. Prevalence, Severity, and Unmet Need for Treatment of Mental Disorders in the World Health Organization World Mental Health Surveys

CONTEXT: Little is known about the extent or severity of untreated mental disorders, especially in less-developed countries.

OBJECTIVE. To estimate prevalence, severity, and treatment of *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (DSM-IV)* mental disorders in 14 countries (6 less developed, 8 developed) in the World Health Organization (WHO) World Mental Health (WMH) Survey Initiative.

DESIGN, SETTING, AND PARTICIPANTS. Face-to-face household surveys of 60 463 community adults conducted from 2001-2003 in 14 countries in the Americas, Europe, the Middle East, Africa, and Asia.

MAIN OUTCOME MEASURES: The *DSM-IV* disorders, severity, and treatment were assessed with the WMH version of the WHO Composite

International Diagnostic Interview (WMH-CIDI), a fully structured, lay-administered psychiatric diagnostic interview.

RESULTS: The prevalence of having any WMH-CIDI/*DSM-IV* disorder in the prior year varied widely, from 4.3% in Shanghai to 26.4% in the United States, with an interquartile range (IQR) of 9.1%-16.9%. Between 33.1% (Colombia) and 80.9% (Nigeria) of 12-month cases were mild (IQR, 40.2%-53.3%). Serious disorders were associated with substantial role disability. Although disorder severity was correlated with probability of treatment in almost all countries, 35.5% to 50.3% of serious cases in developed countries and 76.3% to 85.4% in less-developed countries received no treatment in the 12 months before the interview. Due to the high prevalence of mild and subthreshold cases, the number of those who received treatment far exceeds the number of untreated serious cases in every country.

CONCLUSIONS: Reallocation of treatment resources could substantially decrease the problem of unmet need for treatment of mental disorders among serious cases. Structural barriers exist to this reallocation. Careful consideration needs to be given to the value of treating some mild cases, especially those at risk for progressing to more serious disorders.

JAMA. 2004;291:2581-2590

1: Health Serv Res. 2000 Apr;35(1 Pt 2):277-92.

29. Utilization of specialty mental health care among persons with severe mental illness: the roles of demographics, need, insurance, and risk.

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OBJECTIVE: To examine the sociodemographic, need, risk, and insurance characteristics of persons with severe mental illness and the importance of these characteristics for predicting specialty mental health utilization among this group. DATA SOURCE: The Healthcare for Communities survey, a national study that tracks alcohol, drug, and mental health services utilization. Data come from a telephone survey of adults from 60 communities across the United States, and from a supplemental geographically dispersed sample. STUDY DESIGN: Respondents were categorized as having a severe mental disorder, other mental disorder, or no measured mental disorder. Differences among groups in sociodemographics (gender, marital status, race, education, and income), insurance coverage, need for mental health care (symptoms and perceived need), and risk indicators (suicide ideation, criminal involvement, and aggressive behavior) are examined. Measures of service use for mental health care include emergency room, inpatient, and

specialty outpatient care. The importance of sociodemographics, need, insurance status, and risk indicators for specialty mental health care utilization are examined through logistic regression.

PRINCIPAL FINDINGS: The severely mentally ill in this study are disproportionately African American, unmarried, male, less educated, and have lower family incomes than those with other disorders and those with no measured mental disorders. In a 12-month period almost three-fifths of persons with severe mental illness did not receive specialty mental health care. One in five persons with severe mental illness are uninsured, and Medicare or Medicaid insures 37 percent. Persons covered by these public programs are over six times more likely to have access to specialty care than the uninsured are. Involvement in the criminal justice system also increases the probability that a person will receive care by a factor of about four, independent of level of need. The average number of outpatient visits for specialty care varies little across type of disorder, and the median number of visits (ten) is equivalent for those with a severe mental illness and those with other disorders.

CONCLUSIONS: Persons with severe mental illness have a high level of economic and social disadvantage. Barriers to care, including lack of insurance, are substantial and many do not receive specialty care. Public insurance programs are the major points of leverage for improving access, and policy interventions should be targeted to these programs. Problems of adequate care for the severely mentally ill may be exacerbated by the managed care trend to reductions in intensity of treatment.

PMID: 10778815 [PubMed - indexed for MEDLINE]

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PMID:11826239

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Uninsured and unstably insured: the importance of continuous insurance coverage. [Health Serv Res. 2000]

PMID:10778809

Mental health care use, morbidity, and socioeconomic status in the United States and Ontario. [Inquiry. 1997]

PMID:9146506

Twelve-month use of mental health services in the United States: results from the National Comorbidity Survey Replication. [Arch Gen Psychiatry. 2005]

PMID:15939840

1: Am J Psychiatry. 1994 Dec;151(12):1785-90.

30. The relationship between insurance coverage and psychiatric disorder in predicting use of mental health services.

Landerman LR, Burns BJ, Swartz MS, Wagner HR, George LK.

Department of Psychiatry, Duke University Medical Center, Durham, NC 27710.

OBJECTIVE: This study investigated how insurance coverage for mental health services affects outpatient mental health service utilization among those with and among those without a DSM-III psychiatric diagnosis. The authors used a representative community sample to compare the regression effects of insurance coverage on utilization of mental health services among these subjects.

METHOD: Data are from the second wave of the Piedmont, North Carolina, site of the Epidemiologic Catchment Area project. These data contain DSM-III diagnostic measures derived from the National Institute of Mental Health Diagnostic Interview Schedule as well as measures of insurance coverage and utilization.

Responses from 2,889 community residents were analyzed using both ordinary least squares and logistic regression. RESULTS: In both models, insurance coverage was strongly associated with care among those with as well as among those without a psychiatric disorder. The association between coverage and the probability of care was strongest among those with a disorder. CONCLUSIONS: The findings are not consistent with the claim that failing to provide insurance coverage will reduce discretionary but not necessary mental health care utilization. They provide evidence that failing to provide insurance coverage will reduce utilization as much or more among those with a psychiatric disorder as among those without. This result has important implications for health care reform.

PMID: 7977886 [PubMed - indexed for MEDLINE]

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How do HMOs reduce outpatient mental health care costs? [Am J Psychiatry. 1991]

PMID:1984713

Utilization of specialty mental health care among persons with severe mental illness: the roles of demographics, need, insurance, and risk. [Health Serv Res. 2000]

PMID:10778815

Trends in mental health insurance benefits and out-of-pocket spending. [J Ment Health Policy Econ. 2002]

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Predicting the use of outpatient mental health services: do modeling approaches make a difference? [Inquiry. 2002]

PMID:12371570

1: Psychiatry Clin Neurosci. 2006 Apr;60(2):240-8.

31. Twelve-month use of mental health services in four areas in Japan: findings from the World Mental Health Japan Survey 2002-2003.

Naganuma Y, Tachimori H, Kawakami N, Takeshima T, Ono Y, Uda H, Hata Y, Nekane Y, Nakane H, Iwata N, Furukawa TA, Kikkawa T.

National Institute of Mental Health, National Center of Neurology and Psychiatry, Tokyo, Japan. naganuma@ncnp-k.go.jp

The aim of the present study was to provide basic descriptive data regarding utilization of 12-month mental health services in the Japanese community population. Face-to-face household surveys were carried out in four areas (two urban cities and two rural municipalities), and a total of 1663 persons participated (overall response rate: 56.4%). For data collection, the structured psychiatric interview, World Mental Health version of the World Health Organization Composite International Diagnostic Interview (WMH-CIDI) was used, allowing DSM-IV diagnoses, severity, and service utilization. It was found that 7.3% of total respondents had received any service, either professional or non-professional, in the past 12 months, including 20.0% of those with 12-month DSM-IV disorders and 6.2% of those without. Thirty-three percent of those with any mood disorder used any service, and 26.8% of those used some type of health care. The probability of people with 13-15 years of education receiving mental health treatment was fourfold higher than those with >or=16 years of education. Gender, age, or income were not found to contribute to utilization of mental health services. The results confirm that the majority of people with a recent psychiatric disorder have not used mental health care or other support systems. The mental health care system in Japan has improved over the past decade, but not enough for people suffering from mental disturbances.

PMID: 16594950 [PubMed - indexed for MEDLINE]

Related Links

Twelve-month prevalence, severity, and treatment of common mental disorders in communities in Japan: preliminary finding from the World Mental Health Japan Survey 2002-2003. [Psychiatry Clin Neurosci. 2005]

PMID:16048450

Twelve-month and lifetime health service use in Te Rau Hinengaro: The New Zealand Mental Health Survey. [Aust N Z J Psychiatry. 2006]

PMID:16959011

Twelve-month use of mental health services in the United States: results from the National Comorbidity Survey Replication. [Arch Gen Psychiatry. 2005]

PMID:15939840

Ethnic comparisons of the 12 month prevalence of mental disorders and treatment contact in Te Rau Hinengaro: the New Zealand Mental Health Survey. [Aust N Z J Psychiatry. 2006]

PMID:16959017

Te Rau Hinengaro: the New Zealand Mental Health Survey: overview of methods and findings. [Aust N Z J Psychiatry. 2006]

PMID:16959009

1: Depress Anxiety. 2005;22(3):130-7.

32. Frequency and patterns of mental health services utilization among adolescents with anxiety and depressive disorders.

Essau CA.

School of Human and Life Sciences, Roehampton University, Whitelands College, London, UK. c.essau@roechampton.ac.uk

The main aim of this study was to examine the frequency and patterns of mental health services utilization among 12- to 17-year-old adolescents with anxiety and depressive disorders. Another aim was to examine the factors associated with the use of mental health services. The study population comprised 1,035 adolescents randomly recruited from 36 schools. Anxiety and depressive disorders were coded based on DSM-IV criteria using the computerized Munich version of the Composite International Diagnostic Interview. Only 18.2% of the adolescents who met DSM-IV criteria for anxiety disorders, and 23% of those with depressive disorders, used mental health services. Among adolescents with anxiety disorders, mental health services utilization was associated with past suicide attempt, older age, the presence of comorbid disorders, as well as parental anxiety and depression. The only factor that predicts the use of mental health service among adolescents with depressive disorder was a history of suicide attempt. The implication of the results in terms of tailoring services for children and adolescents with anxiety and depressive disorders are discussed. Copyright 2005 Wiley-Liss, Inc.

PMID: 16175563 [PubMed - indexed for MEDLINE]

Related Links

Comorbidity of anxiety disorders in adolescents. [Depress Anxiety. 2003]

PMID:12900947

Quality of mental health care for youth with asthma and comorbid anxiety and depression. [Med Care. 2006]

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Depressive and disruptive disorders and mental health service utilization in children and adolescents. [J Am Acad Child Adolesc Psychiatry. 1999]

PMID:10504806

Latent class analysis of anxiety and depressive symptoms in referred adolescents. [J Affect Disord. 2005]

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Utilization of health services in relation to mental health problems in adolescents: a population based survey. [BMC Public Health. 2006]

PMID:16480522

1: J Am Acad Child Adolesc Psychiatry. 1997 Jul;36(7):890-900.

33. Mental disorders and service utilization among youths from homeless and low-income housed families.

Buckner JC, Bassuk EL.

Better Homes Fund, Newton, MA 02159, USA.

OBJECTIVE: To assess the mental health of homeless and poor housed youths, using the National Institute of Mental Health (NIMH) Diagnostic Interview Schedule for Children (DISC) Version 2.3, and to examine mental health service use.

METHOD: As part of a comprehensive study of homeless and housed families Worcester, MA, data were collected on 41 homeless and 53 poor housed (never homeless) youths aged 9 to 17 using both the parent and youth versions of the DISC. RESULTS: On the basis of the parent version of the DISC, current (6-month) prevalence rates of DSM-III-R disruptive behavior, affective, and anxiety disorders were comparable in homeless and housed youths but higher than rates found among youths in the NIMH-sponsored Methods for the Epidemiology of Child and Adolescent Mental Disorders (MECA) Study, which used the same diagnostic measure. Approximately 32% of the combined sample of homeless and housed youths had a current mental disorder accompanied by impairment in functioning. Mental health service use in the preceding 6 months among youths who had one or more current disorders and associated impairment ranged from 20% to 35%. A subgroup of youths with one or more current disorders and poor global functioning had never received treatment. CONCLUSIONS: This sample of homeless and housed youths was found to have high rates of current mental disorders. Use of mental health services by children with mental health needs was low, particularly for youths with poor overall functioning.

PMID: 9204666 [PubMed - indexed for MEDLINE]

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Hunger: its impact on children's health and mental health. [Pediatrics. 2002]

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The NIMH Diagnostic Interview Schedule for Children Version 2.3 (DISC-2.3): description, acceptability, prevalence rates, and performance in the MECA Study.

Methods for the Epidemiology of Child and Adolescent Mental Disorders Study. [J Am Acad Child Adolesc Psychiatry. 1996]

PMID:8768346

The DSM-IV rates of child and adolescent disorders in Puerto Rico: prevalence, correlates, service use, and the effects of impairment. [Arch Gen Psychiatry. 2004] PMID:14706947

Mental health service use in the community and schools: results from the four-community MECA Study. Methods for the Epidemiology of Child and Adolescent Mental Disorders Study. [J Am Acad Child Adolesc Psychiatry. 1996]

PMID:8768348

Determinants of health and service use patterns in homeless and low-income housed children. [Pediatrics. 1998]

PMID:9738176

1: Am J Psychiatry. 2005 Sep;162(9):1723-32.

34. Prevalence of mental disorders and utilization of mental health services in two American Indian reservation populations: mental health disparities in a national context.

Beals J, Novins DK, Whitesell NR, Spicer P, Mitchell CM, Manson SM.

American Indian and Alaska Native Programs, University of Colorado at Denver and Health Sciences Center, MS F800, PO Box 6508, Aurora, CO 80045-0508, USA. jan.beals@uchsc.edu

OBJECTIVE: The American Indian Service Utilization, Psychiatric Epidemiology, Risk and Protective Factors Project (AI-SUPERPFP) provided estimates of the prevalence of DSM-III-R disorders and utilization of services for help with those disorders in American Indian populations. Completed between 1997 and 1999, the AI-SUPERPFP was designed to allow comparison of findings with the results of the baseline National Comorbidity Survey (NCS), conducted in 1990-1992, which reflected the

general United States population. METHOD: A total of 3,084 tribal members (1,446 in a Southwest tribe and 1,638 in a Northern Plains tribe) age 15-54 years living on or near their home reservations were interviewed with an adaptation of the University of Michigan Composite International Diagnostic Interview. The lifetime and 12-month prevalences of nine DSM-III-R disorders were estimated, and patterns of help-seeking for symptoms of mental disorders were examined. RESULTS: The most common lifetime diagnoses in the American Indian populations were alcohol dependence, posttraumatic stress disorder (PTSD), and major depressive episode. Compared with NCS results, lifetime PTSD rates were higher in all American Indian samples, lifetime alcohol dependence rates were higher for all but Southwest women, and lifetime major depressive episode rates were lower for Northern Plains men and women. Fewer disparities for 12-month rates emerged. After differences in demographic variables were accounted for, both American Indian samples were at heightened risk for PTSD and alcohol dependence but at lower risk for major depressive episode, compared with the NCS sample. American Indian men were more likely than those in NCS to seek help for substance use problems from specialty providers; American Indian women were less likely to talk to nonspecialty providers about emotional problems. Help-seeking from traditional healers was common in both American Indian populations and was especially common in the Southwest. CONCLUSIONS: The results suggest that these American Indian populations had comparable, and in some cases greater, mental health service needs, compared with the general population of the United States.

PMID: 16135633 [PubMed - indexed for MEDLINE]

Related Links

Prevalence of DSM-IV disorders and attendant help-seeking in 2 American Indian reservation populations. [Arch Gen Psychiatry. 2005]

PMID:15630077

Prevalence of major depressive episode in two American Indian reservation populations: unexpected findings with a structured interview. [Am J Psychiatry. 2005]

PMID:16135632

The prevalence of DSM-III-R alcohol dependence in two American Indian populations. [Alcohol Clin Exp Res. 2003]

PMID:14634495

Lifetime and 12-month prevalence of DSM-III-R psychiatric disorders in the United States. Results from the National Comorbidity Survey. [Arch Gen Psychiatry. 1994]

PMID:8279933

Challenges in operationalizing the DSM-IV clinical significance criterion. [Arch Gen Psychiatry. 2004]

PMID:15583111

1: J Clin Psychiatry. 2006 Jun;67(6):925-32.

35. A gender-focused perspective on health service utilization in comorbid bipolar I disorder and alcohol use disorders: results from the national epidemiologic survey on alcohol and related conditions.

Goldstein BI, Levitt AJ.

From the Mood Disorders Program, Department of Psychiatry, Sunnybrook and Women's College Health Sciences Centre, University of Toronto, Toronto, Ontario, Canada.

OBJECTIVES: This study compares health service utilization by individuals with comorbid lifetime bipolar I disorder and lifetime alcohol use disorders (AUD) to that of individuals with either diagnosis alone, using nationally representative data. METHOD: The 2001-2002 National Epidemiologic Survey on Alcohol and Related Conditions was used to identify respondents with bipolar I disorder only (BD-only; N = 636), AUD only (N = 11,068), and comorbid bipolar I disorder and AUD (BD-AUD; N = 775). Diagnoses were generated using the National Institute on Alcohol Abuse and Alcoholism Alcohol Use Disorder and Associated Disabilities Interview Schedule-DSM-IV Version. The 3 groups were compared with respect to self-reported health service utilization. RESULTS: For both men and women, respondents in the BD-AUD group were significantly more likely than AUD-only respondents to report any alcohol-related service utilization ($p < .001$). BD-AUD respondents were significantly more likely to report bipolar disorder-related hospital admissions as compared with BD-only respondents among males only ($p = .009$). Within the BD-AUD group, males reported significantly greater utilization of AUD treatment only ($p < .001$), and females reported significantly greater utilization of bipolar disorder treatment only ($p < .001$) and significantly greater likelihood of utilizing mental health services overall ($p < .001$). There was no gender difference in the proportion of respondents who utilized both AUD and bipolar disorder services. CONCLUSIONS: As expected, individuals with comorbid bipolar I disorder and AUD utilize significantly more mental health services than individuals with either disorder alone. The primary original finding is that among those with comorbid bipolar I disorder and AUD, bipolar I disorder is more likely to go untreated among males and AUD is more likely to go untreated among females. Gender may be an important factor to consider in future health service planning for comorbid bipolar I disorder and AUD.

PMID: 16848652 [PubMed - in process]

Related Links

Factors associated with temporal priority in comorbid bipolar I disorder and alcohol use disorders: Results from the national epidemiologic survey on alcohol and related conditions. [J Clin Psychiatry. 2006]

PMID:16669730

Alcohol treatment utilization: Findings from the National Epidemiologic Survey on Alcohol and Related Conditions. [Drug Alcohol Depend. 2007]

PMID:16919401

The prevalence and impact of migraine headache in bipolar disorder: resultsfrom the Canadian Community Health Survey. [Headache. 2006]

PMID:16732843

Concurrent tracking of alcohol use and bipolar disorder symptoms. [Bipolar Disord. 2006]

PMID:16879134

Alcoholism and anxiety in bipolar illness: Differential lifetime anxiety comorbidity in bipolar I women with and without alcoholism. [J Affect Disord. 2007]

PMID:17254638

1: Arch Gen Psychiatry. 1984 Oct;41(10):971-8.

36. Utilization of health and mental health services. Three Epidemiologic Catchment Area sites.

Shapiro S, Skinner EA, Kessler LG, Von Korff M, German PS, Tischler GL, Leaf PJ, Benham L, Cottler L, Regier DA.

Utilization of health and mental health services by non-institutionalized persons aged 18 years and older is examined based on interviews with probability samples of 3,000 to 3,500 persons in each of three sites of the National Institute of Mental Health Epidemiologic Catchment Area (ECA) program: New Haven, Conn, Baltimore, and St Louis. In all three ECAs, 6% to 7% of the adults made a visit during the prior six months for mental health reasons; proportions were considerably higher among persons with recent DSM-III disorders covered by the Diagnostic Interview Schedule (DIS) or severe cognitive impairment. Between 24% and 38% of all ambulatory visits by persons with DIS disorders were to mental health specialists. In seeking mental health services, men were more likely to turn to the specialty sector than to the generalist; women used both sectors about equally. The aged infrequently received care from mental health specialists. Visits for mental health reasons varied considerably depending on specific types of DIS disorder.

PMID: 6477055 [PubMed - indexed for MEDLINE]

Related Links

Utilization of health and mental health services by Los Angeles Mexican Americans and non-Hispanic whites. [Arch Gen Psychiatry. 1987]

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PMID:6332591

Use of services by persons with mental and addictive disorders. Findings from the National Institute of Mental Health Epidemiologic Catchment Area Program. [Arch Gen Psychiatry. 1993]

PMID:8381266

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PMID:6089692

The de facto US mental and addictive disorders service system. Epidemiologic catchment area prospective 1-year prevalence rates of disorders and services.[Arch Gen Psychiatry. 1993]

PMID:8427558

1: Drug Alcohol Depend. 2007 Jan 12;86(2-3):214-21. Epub 2006 Aug 17.

37. Alcohol treatment utilization: Findings from the National Epidemiologic Survey on Alcohol and Related Conditions.

Cohen E, Feinn R, Arias A, Kranzler HR.

Alcohol Research Center, Department of Psychiatry, University of Connecticut Health Center, Farmington, CT 06030-2103, United States.

BACKGROUND: Epidemiological studies consistently show low rates of alcohol treatment utilization among individuals with an alcohol use disorder (AUD). However, there is not as great consistency in the characteristics that predict alcohol treatment utilization. METHODS: Using data from the National Epidemiologic Survey on Alcohol and Related Conditions (NESARC), we examined attributes associated with treatment utilization among individuals with an AUD. We used stepwise backward selection logistic regression analysis to examine demographic and clinical predictors of treatment utilization, in order to identify opportunities to improve the delivery of services to this population.

RESULTS: Only 14.6% of individuals who met lifetime criteria for an AUD reported ever having received alcohol treatment (including self-help group participation). A greater proportion of respondents with both alcohol abuse and dependence (27.9%) reported having received treatment, compared with 7.5% of those with alcohol abuse only and 4.8% of those with alcohol dependence only. Older individuals, men, and those who were divorced, had less education or more lifetime comorbid mood, personality, and drug use disorders were also more likely to have received treatment.

CONCLUSIONS: The majority of individuals with an AUD never receive formal alcohol treatment, nor do they participate in self-help groups. Although natural recovery from an AUD is well documented, participation in alcohol treatment is associated with improved outcomes. The data presented here should be taken into account when efforts are made to enhance alcohol treatment utilization.

PMID: 16919401 [PubMed - in process]

Related Links

A gender-focused perspective on health service utilization in comorbid bipolar I disorder and alcohol use disorders: results from the national epidemiologic survey on alcohol and related conditions. [J Clin Psychiatry. 2006]

PMID:16848652

Factors associated with temporal priority in comorbid bipolar I disorder and alcohol use disorders: Results from the national epidemiologic survey on alcohol and related conditions. [J Clin Psychiatry. 2006]

PMID:16669730

Estimating the effect of help-seeking on achieving recovery from alcohol dependence. [Addiction. 2006]

PMID:16696626

Comorbidity between DSM-IV alcohol and specific drug use disorders in the United States: results from the National Epidemiologic Survey on Alcohol and Related Conditions. [Drug Alcohol Depend. 2005]

PMID:16157233

Influence of psychiatric comorbidity in alcohol-dependent subjects in a representative population survey on treatment utilization and natural recovery. [Addiction. 2005]

PMID:15733254

1: Acta Psiquiatr Psicol Am Lat. 1991 Jun;37(2):143-7.

38. Use of health services in Puerto Rico by persons with mental disorders.

[Article in Spanish]

Martinez RE, Sesman Rodriguez M, Bravo M, Canino G, Rubio-Stipec M.

Escuela de Salud Publica, Universidad de Puerto Rico, San Juan.

As part of a major study on the prevalence of mental disorders in Puerto Rico, this paper describes the mental health care utilization patterns of persons with a DIS/DSM-III disorder within the last year. The main findings of this analysis show that (a) There is a high rate of health service utilization, (b) The public sector is the main provider of services, (c) People with a DIS disorder tend to resort to the non-psychiatric physician, (d) People with alcohol abuse and/or dependence tend to use the services of general practitioners while schizophrenics, somatizers, and people with cognitive impairment tend to apply for the services of mental health specialists. Seeking help from other sources such as clergymen or spiritualists does not substitute the use of health

services.

PMID: 1799132 [PubMed - indexed for MEDLINE]

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[Utilization of health services in Puerto Rico of persons with mental disorders] [P R Health Sci J. 1991]

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The DSM-IV rates of child and adolescent disorders in Puerto Rico: prevalence, correlates, service use, and the effects of impairment. [Arch Gen Psychiatry. 2004]

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Help-seeking for psychiatric disorders. [Can J Psychiatry. 1997]

PMID:9429063

Patterns of mental health utilization among island Puerto Rican poor. [Am J Public Health. 1991]

PMID:2053664

The de facto US mental and addictive disorders service system. Epidemiologic catchment area prospective 1-year prevalence rates of disorders and services. [Arch Gen Psychiatry. 1993]

PMID:8427558

1: Soc Psychiatry Psychiatr Epidemiol. 1998 Jun;33(6):291-8.

39. Factors related to utilization of services for mental health reasons in Montreal, Canada.

Lefebvre J, Lesage A, Cyr M, Toupin J, Fournier L.

Centre de Recherche Fernand-Seguin, Hopital Louis-H Lafontaine, Montreal, Quebec, Canada.

This study examines factors related to the utilization of services for mental health reasons by Montreal residents. Data were drawn from telephone interviews. A random sample of 893 respondents completed a questionnaire on service utilization and the Diagnostic Interview Schedule Self Administered to assess DSM-III-R psychiatric disorders. Results indicate that 12.8% of the population had used such services in the past year. Medical doctors and psychiatrists, whose services are free of charge under universal health coverage, were consulted, respectively, by 4.1% and 2.0% of respondents. Psychologists, whose services are not free, were seen by 3.4% of respondents. In all, 42.0% of respondents who presented a current diagnosis used services in the past year. The highest proportion of users (48.0%) was found among respondents who presented both current and lifetime diagnoses and among respondents with comorbidity. The choice of caregiver was related also to pattern of disorders: respondents with current and comorbid disorders tended to consult general practitioners, while respondents with lifetime disorders or with lifetime and current disorders favoured specialized care. In line with other studies, self-perception of mental health, gender and marital status were related to utilization; unlike other studies, attitudes and age were not. It is argued that particularities found in this study stem not only from methodological considerations, but also from the configuration of the mental health system in Quebec, where the greater availability of psychologists may facilitate service utilization.

PMID: 9640098 [PubMed - indexed for MEDLINE]

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Telephone surveys as an alternative for estimating prevalence of mental disorders and service utilization: a Montreal catchment area study. [Can J Psychiatry. 1997]

PMID:9307834

Utilization of medical services by Veterans Health Study (VHS) respondents. [J Ambul Care Manage. 2005]

PMID:15923946

The use of mental health services in Ontario: epidemiologic findings. [Can J Psychiatry. 1996]

PMID:8946080

Influence of comorbid alcohol and psychiatric disorders on utilization of mental health services in the National Comorbidity Survey. [Am J Psychiatry. 1999]

PMID:10450265

[Old and new long stay patients in French psychiatric institutions: results from a national random survey with two-year follow-up] [Encephale. 2005]

PMID:16389714

1: Can J Psychiatry. 2005 Oct;50(12):753-61.

40. Mental health service use in a nationally representative Canadian survey.

Sareen J, Cox BJ, Afifi TO, Yu BN, Stein MB.

Department of Psychiatry, University of Manitoba, Winnipeg. sareen@cc.umanitoba.ca

BACKGROUND: Previous Canadian surveys have noted a wide range of prevalence rates for mental health service use and found no consistent relation between type of contact with mental health professionals and severity of illness. This study is the first investigation to examine the prevalence and correlates of mental health service use in a nationally representative Canadian survey.

METHODS: The Canadian Community Health Survey Cycle 1.1 was conducted between 2000 and 2001 (n = 125,493; respondent age 12 years and over; response rate; 84.7%). Respondents were asked whether they had contacted a professional because of emotional symptoms in the past year and about their experience of barriers to treatment. DSM-IV major depression and alcohol dependence diagnoses were assessed with the Composite International Diagnostic Interview Short Form. The relation between a range of measures of clinical severity and the type of professional contacted for emotional symptoms was examined. RESULTS: The prevalence of 12-month help seeking for emotional symptoms was 8.3% (99%CI, 8.10to 8.55); an additional 0.6% (99%CI, 0.49 to 0.62) of the sample perceived a need for treatment without seeking care. Respondents endorsing contact with multiple professionals or with psychiatrists only had higher levels of severity than those who had contact with family doctors only or nonphysician professionals only. CONCLUSIONS: Although untreated depression remains a significant problem in Canada, more severe illness was more likely to be associated with seeing a psychiatrist (or multiple professionals), indicating a relation between greater severity of mental illness and receiving more specialized care.

PMID: 16408523 [PubMed - indexed for MEDLINE]

Related Links

Perceived need for mental health treatment in a nationally representative Canadian sample. [Can J Psychiatry. 2005]

PMID:16276856

The prevalence and correlates of untreated serious mental illness. [Health Serv Res. 2001]

PMID:11775672

Service use for mental health reasons: cross-provincial differences in rates, determinants, and equity of access. [Can J Psychiatry. 2005]

PMID:16276852

Suicidal behaviour in Te Rau Hinengaro: the New Zealand Mental Health Survey. [Aust N Z J Psychiatry. 2006]

PMID:16959016

Ethnic comparisons of the 12 month prevalence of mental disorders and treatment contact in Te Rau Hinengaro: the New Zealand Mental Health Survey. [Aust N Z J Psychiatry. 2006]

PMID:16959017

1: Arch Gen Psychiatry. 2005 Jan;62(1):99-108.

41. Prevalence of DSM-IV disorders and attendant help-seeking in 2 American Indian reservation populations.

Beals J, Manson SM, Whitesell NR, Spicer P, Novins DK, Mitchell CM.

American Indian and Alaska Native Programs, University of Colorado Health Sciences Center, Aurora, CO 80045, USA. jan.beals@uchsc.edu

BACKGROUND: The American Indian Service Utilization, Psychiatric Epidemiology, Risk and Protective Factors Project (AI-SUPERPFP) estimated the mental health burden and associated help-seeking in select American Indian reservation communities. OBJECTIVE: To determine the lifetime and 12-month prevalence of common DSM-IV disorders, their demographic correlates, and patterns of help-seeking in 2 culturally distinct American Indian reservation communities in the Southwest and Northern Plains. DESIGN: Completed between 1997 and 2000, a cross-sectional probability sample survey. SETTING: General community.

PARTICIPANTS: Three thousand eighty-four (Southwest = 1446 and Northern Plains = 1638) members, aged 15-54 years, of 2 tribal groups living on or near their home reservations were randomly sampled from the tribal rolls. Response rates were 73.7% and 76.8% for the Southwest and Northern Plains tribes, respectively.Main Outcomes Measures The AI-SUPERPFP Composite International Diagnostic Interview, a culturally adapted version of the University of Michigan version of the Composite

International Diagnostic Interview, to assess DSM-IV diagnoses and help-seeking. RESULTS: Overall lifetime prevalence of AI-SUPERPFP DSM-IV disorders ranged from 35.7% for Southwest women to near 50% for both groups of men. Alcohol abuse and dependence were the most common disorders for men, with posttraumatic stress disorder most prevalent for women. Many of those with lifetime alcohol problems or posttraumatic stress disorder no longer met criteria for 12-month diagnoses. Significant levels of comorbidity were found between those with depressive and/or anxiety and substance disorders. Demographic correlates other than tribe, sex, and age were generally unrelated to disorder status. A majority of participants with lifetime disorders had sought help from mental health professionals, other medical personnel, or culturally traditional sources. CONCLUSIONS: Alcohol disorders and posttraumatic stress disorder were more common in these American Indian populations than in other populations using comparable methods. Substantial comorbidity between depressive and/or anxiety and substance disorders suggests the need for greater coordination of treatment for comorbid disorders.

PMID: 15630077 [PubMed - indexed for MEDLINE]

Related Links

Prevalence of mental disorders and utilization of mental health services in two American Indian reservation populations: mental health disparities in a national context. [Am J Psychiatry. 2005]

PMID:16135633

Prevalence of major depressive episode in two American Indian reservation populations: unexpected findings with a structured interview. [Am J Psychiatry. 2005]

PMID:16135632

Challenges in operationalizing the DSM-IV clinical significance criterion. [Arch Gen Psychiatry. 2004]

PMID:15583111

The prevalence of DSM-III-R alcohol dependence in two American Indian populations. [Alcohol Clin Exp Res. 2003]

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Help seeking for substance use problems in two American Indian reservation populations. [Psychiatr Serv. 2006]

PMID:16603747

1: Can J Psychiatry. 1997 Nov;42(9):935-42.

Comment in: Can J Psychiatry. 1998 Oct;43(8):857-8.

42. Help-seeking for psychiatric disorders.

Bland RC, Newman SC, Orn H.

Department of Psychiatry, University of Alberta, Edmonton.

OBJECTIVE: To examine demographic and clinical determinants of seeking help for mental or emotional problems. To determine the proportion of those people with a disorder who sought help. To determine what categories of professionals are sought by those who get care. METHOD: A 2-stage random sample of 3956 adult residents of Edmonton, Alberta, Canada was interviewed by trained lay interviewers using the Diagnostic Interview Schedule (DIS) (73% completion rate). An average of 2.8 years later, a systematic random sample of 1964 subjects was reinterviewed (an 86% completion rate) using the DIS and a health care utilization questionnaire. After adjusting for age and sex, the reinterview sample was representative of those with and without a diagnosis at the first interview. RESULTS: Of the 1964 subjects, 570 (31%) met criteria for a DIS/DSM-III diagnosis in the year preceding the interview (one-year prevalence rate). These diagnoses included generalized anxiety disorder (GAD) and posttraumatic stress disorder (PTSD). For those with a diagnosis, sex, age, marital status, education, employment, and income were examined as determinants of help-seeking. Only sex (female) and age (under 45) were significant predictors. Comorbidity was highly significant: the help-seeking rate for those with one diagnosis was 20.3%; for those with more than one diagnosis, the rate was 42.8% (OR = 2.94, chi 2 = 31.4, df = 1, $P < 0.001$). Just over 28% of those with a diagnosis saw any health care professional, and 7.7% of those without a diagnosis sought help for a mental or emotional problem. A specific diagnosis made a difference: 46.7% of those with a major depressive episode sought help, but only 16.0% of those with alcohol abuse or dependence sought care.

CONCLUSION: Major determinants of help-seeking are sex (female), age (under 45), severity of the illness, and comorbidity. A surprisingly high proportion of those with a disorder (72%) do not seek help, and over one-third of those seeking help do not have a current DIS/DSM-III disorder.

PMID: 9429063 [PubMed - indexed for MEDLINE]

Related Links

Prevalence of DSM-IV disorders and attendant help-seeking in 2 American Indian reservation populations. [Arch Gen Psychiatry. 2005]

PMID:15630077

Perceived need for mental health treatment in a nationally representative Canadian sample. [Can J Psychiatry. 2005]

PMID:16276856

[Cannabis and schizophrenia: demographic and clinical correlates] [Encephale. 2003]

PMID:12640322

Mental health service use in a nationally representative Canadian survey. [Can J Psychiatry. 2005]

PMID:16408523

Epidemiology of psychiatric disorders in Edmonton. Panic disorder. [Acta Psychiatr Scand Suppl. 1994]

PMID:8178684

1: Can J Psychiatry. 2005 Feb;50(2):87-94.

43. The relation between perceived need for mental health treatment, DSM diagnosis, and quality of life: a Canadian population-based survey.

Sareen J, Stein MB, Campbell DW, Hassard T, Menec V.

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OBJECTIVES: Prevalence estimates of mental disorders were designed to provide an indirect estimate of the need for mental health services in the community. However, recent studies have demonstrated that meeting criteria for a DSM-based disorder does not necessarily equate with need for treatment. The current investigation examined the relation between self-perceived need for mental health treatment and DSM diagnosis, with respect to quality of life (QoL) and suicidal ideation. METHODS: Data came from an Ontario population-based sample of 8116 residents (aged 15 to 64 years). The University of Michigan Composite International Diagnostic Interview was used to diagnose mood, anxiety, substance use, and bulimia disorder according to DSM-III-R criteria. We categorized past-year help seeking for emotional symptoms and (or) perceiving a need for treatment without seeking care as self-perceived need for treatment. We used a range of variables to measure QoL: self-perception of mental health status, a validated instrument that measured well-being, and restriction of activities (current, past 30 days, and long-term). RESULTS: Independent of subjects' meeting criteria for a DSM-III-R diagnosis, self-perceived need for treatment was significantly associated with poor QoL (on all measures) and past-year suicidal ideation. CONCLUSIONS: Self-perceived need for mental health treatment, in addition to DSM diagnosis, may provide valuable information for estimating the number of people in the population who need mental health services. The relation between self-perceived need for treatment and objective measures of treatment need requires future study.

PMID: 15807224 [PubMed - indexed for MEDLINE]

Related Links

Perceived need for mental health treatment in a nationally representative Canadian sample. [Can J Psychiatry. 2005]

PMID:16276856

Perceived need and help-seeking in adults with mood, anxiety, or substance use disorders. [Arch Gen Psychiatry. 2002]

PMID:11779286

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PMID:16275812

Perceived need for mental health care: influences of diagnosis, demography and disability. [Psychol Med. 2002]

PMID:11866324

DSM-III-R alcohol abuse and dependence and psychiatric comorbidity in Ontario: results from the Mental Health Supplement to the Ontario Health Survey. [Drug Alcohol Depend. 1995]

PMID:8529531

1: Health Serv Res. 2004 Apr;39(2):393-415.

Comment in: Health Serv Res. 2004 Apr;39(2):221-4.

44. Delays in initial treatment contact after first onset of a mental disorder.

Wang PS, Berglund PA, Olfson M, Kessler RC.

Department of Health Care Policy, Harvard Medical School, Boston, MA 02115, USA.

OBJECTIVE: To examine nationally representative patterns and predictors of delays in contacting a professional after first onset of a mental disorder. DATA SOURCES: The National Comorbidity Survey, a nationally representative survey of 8,098 respondents aged 15-54. STUDY DESIGN: Cross-sectional survey. DATA COLLECTION: Assessed lifetime DSM-III-R mental disorders using a modified version of the Composite International Diagnostic Interview (CIDI). Obtained reports on age at onset of disorders and age of first treatment contact with each of six types of professionals (general medical doctors, psychiatrists, mother mental health specialists, religious professionals, human services professionals, and alternative treatment professionals). Used Kaplan-Meier (KM) curves to estimate cumulative lifetime probabilities of treatment contact after first onset of a mental disorder. Used survival analysis to study the predictors of delays in making treatment contact. PRINCIPAL FINDINGS: The vast majority (80.1 percent) of people with a lifetime DSM-III-R disorder eventually make treatment contact, although delays average more than a decade. The duration of delay is related to less serious disorders, younger age at

onset, and older age at interview. There is no evidence that delay in initial contact with a health care professional is increased by earlier contact with other non-health-care professionals. CONCLUSIONS: Within the limits of recalling lifetime events, it appears that delays in initial treatment contact are an important component of the larger problem of unmet need for mental health care. Interventions are needed to decrease these delays.

PMID: 15032961 [PubMed - indexed for MEDLINE]

Related Links

Failure and delay in initial treatment contact after first onset of mental disorders in the National Comorbidity Survey Replication. [Arch Gen Psychiatry. 2005]

PMID:15939838

Patterns and correlates of contacting clergy for mental disorders in the United States. [Health Serv Res. 2003]

PMID:12785566

Twelve-month use of mental health services in the United States: results from the National Comorbidity Survey Replication. [Arch Gen Psychiatry. 2005]

PMID:15939840

Patterns and predictors of treatment contact after first onset of psychiatric disorders. [Am J Psychiatry. 1998]

PMID:9433340

Twelve-month and lifetime health service use in Te Rau Hinengaro: The New Zealand Mental Health Survey. [Aust N Z J Psychiatry. 2006]

PMID:16959011

1: Health Serv Res. 2005 Oct;40(5 Pt 1):1514-33.

45. Social and economic determinants of disparities in professional help-seeking for child mental health problems: evidence from a national sample.

Zimmerman FJ.

Department of Health Services and Child Health Institute, University of Washington, 6200 NE 74th Street, Suite 210, Seattle, WA 98115-8160, USA.

OBJECTIVE: To test the role of social determinants-including race, education, income, and demographic factors-of child mental health services use, defined as having had a visit to a mental health professional for depression, attention-deficit, or for any reason. DATA SOURCES/STUDY SETTING: National Longitudinal Survey of Youth and the

Child/Young Adult supplement, a nationally representative sample of 7-14-year-old children born to women who were 14-22 years old at the start of data collection, in 1979. African Americans and Latinos were over-sampled, and population weights are available to make nationally representative inferences. STUDY DESIGN: Indicators of mental health service use were regressed on social and economic determinants, family structure variables, and insurance variables, controlling for need as captured by several different symptom scales. PRINCIPAL FINDINGS: Girls are much less likely to obtain needed treatment for externalizing behavior disorders than are boys, and are somewhat less likely to obtain needed treatment for depression than boys. Middle children are less likely to obtain needed treatment for any mental health problem than are oldest, youngest, or only children. The presence of the father inhibits the likelihood that the child will receive treatment, particularly for depression. African Americans and Latinos are less likely than white children to receive treatment. In contrast to these rich results for the social and demographic determinants of children's specialty mental health utilization, the economic and insurance variables (including maternal education and income) seem to hold little predictive power. CONCLUSIONS: These results argue for interventions to sensitize parents-especially fathers-to the need to pay attention to the mental health needs of their children, in particular girls and middle children. The analysis also suggests that the literature on intrahousehold decision making and on the gender dimensions of investment in children is worth extending to mental health treatment decisions.

PMID: 16174145 [PubMed - indexed for MEDLINE]

Related Links

Inequalities in use of specialty mental health services among Latinos, African Americans, and non-Latino whites. [Psychiatr Serv. 2002]

PMID:12461214

Geographic disparities in children's mental health care. [Pediatrics. 2003]

PMID:14523217

Utilization of specialty mental health care among persons with severe mental illness: the roles of demographics, need, insurance, and risk. [Health Serv Res. 2000]

PMID:10778815

Access to specialty mental health services among women in California. [Psychiatr Serv. 2005]

PMID:15939951

Determinants of ambulatory mental health services use for school-age children and adolescents. [Health Serv Res. 1996]

PMID:8885856

1: Ment Health Serv Res. 2004 Mar;6(1):33-46.

46. Assessing population need for mental health care: a review of approaches and predictors.

Aoun S, Pennebaker D, Wood C.

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This review aimed to clarify the concept of need, explore the different approaches used to assess need, and contribute to an improved understanding of predictor and intervening factors in assessing need for mental health services. Two population-based needs assessment approaches have been identified: modeling need for services and surveys of the general population. The most widely used model was that based on the Jarman-8 index of social deprivation. The population-based epidemiological surveys addressed perceived need by seeking direct, self-reported measures of individuals' perceptions of their needs for care. Although many studies have reported correlates of service use, few have attempted to identify correlates of perceived need. The fact that two-thirds to three-quarters of people were identified as meeting criteria for a mental health disorder, but did not report receiving treatment, highlighted a gap between epidemiology and service use. This gap could be explained by a number of intervening factors such as the discordance between diagnosis and disability, the determinants of and barriers to help-seeking behavior, the belief systems concerning appropriate treatments, and choice of health professionals. This review has thus identified the predictor variables which are important for a comprehensive analysis of need for mental health care. Suggestions and challenges have been put forward to address the identified gaps in assessing population need.

PMID: 15002679 [PubMed - indexed for MEDLINE]

Related Links

Perceived need for mental health treatment in a nationally representative Canadian sample. [Can J Psychiatry. 2005]

PMID:16276856

The assessment of need for mental health services. [Soc Psychiatry Psychiatr Epidemiol. 2005]

PMID:16088372

Making psychiatric epidemiology useful: the contribution of epidemiology to government policy. [Acta Psychiatr Scand. 2001]

PMID:11202124

Making psychiatric epidemiology useful: the contribution of epidemiology to government policy. [Int Rev Psychiatry. 2003]

PMID:12745332

Epidemiology and health service resource allocation policy for alcohol, drug abuse, and mental disorders. [Public Health Rep. 1984]

PMID:6435161

1: Psychiatr Serv. 2002 Jun;53(6):730-7.

47. Global Assessment of Functioning ratings and the allocation and outcomes of mental health services.

Moos RH, Nichol AC, Moos BS.

Center for Health Care Evaluation, Program Evaluation and Resource Center of the Veterans Affairs Health Care System, Stanford University, Palo Alto, California, USA. bmoos@stanford.edu

OBJECTIVE: The Global Assessment of Functioning (GAF) is an integral part of the standard multiaxial psychiatric diagnostic system. The purpose of including the GAF in DSM-IV as a tool for axis V assessment is to enable clinicians to obtain information about global functioning to supplement existing data about symptoms and diagnoses and to help predict the allocation and outcomes of mental health treatment. The purpose of this study was to examine the value of the GAF as part of a systemwide program for monitoring the allocation and outcomes of mental health care services. METHODS: Clinicians used the GAF to assess global functioning among 9,854 patients with psychiatric or substance use disorders, or both, who were already participating in an outcomes monitoring program of the Department of Veterans Affairs. A longitudinal prospective follow-up design was used. RESULTS: Patients' clinical diagnoses and symptoms were stronger predictors of GAF ratings than was their social or occupational functioning. GAF-rated impairment was associated with the provision of inpatient or residential care and outpatient psychiatric care, but patients with greater levels of impairment did not receive more treatment. GAF ratings were only minimally associated with treatment outcomes. No robust associations were found between GAF ratings and outcomes as assessed by clinician interview or by patients' self-report at follow-up. CONCLUSIONS: Including GAF ratings in a program for predicting the allocation and outcomes of mental health care is of questionable value. Research is needed to determine whether systematic training and ongoing validity checks would enhance the contribution of the GAF in monitoring service use and outcomes.

PMID: 12045311 [PubMed - indexed for MEDLINE]

Related Links

Global assessment of functioning (GAF) ratings: determinants and role as predictors of one-year treatment outcomes. [J Clin Psychol. 2000]

PMID:10775040

Axis V--Global Assessment of Functioning Scale. Evaluation of a self-report version. [Acta Psychiatr Scand. 1994]

PMID:7872038

Using the GAF as a national mental health outcome measure in the department of Veterans Affairs. [Psychiatr Serv. 2005]

PMID:15812091

Evidence for limited validity of the revised global assessment of functioning scale. [Psychiatr Serv. 1996]

PMID:8837160

Continuity of care and clinical outcomes in a national health system. [Psychiatr Serv. 2005]

PMID:15812092

1: Jt Comm J Qual Improv. 1996 Feb;22(2):125-33.

48. Measuring outcomes in psychiatry: an inpatient model.

Davis DE, Fong ML.

Medical Service Corps. Tripler Army Medical Center, Honolulu.

BACKGROUND: This article describes a system for measuring outcomes recently implemented in the department of psychiatry of Baptist Memorial Hospital, a 78-bed inpatient and day treatment unit that represents one service line of a large, urban teaching hospital in Memphis. In June 1993 Baptist Hospital began a 15-month pilot test of PsychSentinel, a measurement tool developed by researchers in the Department of Community Medicine at the University of Connecticut. The hospital identified the following four primary goals for this pilot project: provide data for internal hospital program evaluation, provide data for external marketing in a managed care environment, satisfy requirements of the Joint Commission on Accreditation of Health Care Organizations, and generate studies that add to the literature in psychiatry and psychology.

DESCRIPTION OF MEASURE: PsychSentinel is based on the standardized diagnostic criteria in the Diagnostic and Statistical Manual of Mental Disorders, 4th edition (DSM-IV). The outcome measure assesses the change in the number of symptoms of psychopathology that occurs between admission and discharge from the hospital. Included in the nonproprietary system are risk adjustment factors, as well as access to a national reference database for comparative analysis purposes. Data collection can be done by trained ancillary staff members, with as much or as little direct physician involvement as desired. The system has proven to be both time effective and cost effective, and it provides important outcome information both at the program level and at the clinician level.

RESULTS: After the pilot test, the staff at Baptist Memorial Hospital determined that the system met all initial objectives identified and recently adopted the system as an ongoing measure of quality patient care in the department of psychiatry.

PMID: 8646301 [PubMed - indexed for MEDLINE]

Related Links

Systematic reviews of the effectiveness of day care for people with severe mental disorders: (1) acute day hospital versus admission; (2) vocational rehabilitation; (3) day hospital versus outpatient care. [Health Technol Assess. 2001]

PMID:11532238

Primary Care Research Team Assessment (PCRTA): development and evaluation. [Occas Pap R Coll Gen Pract. 2002]

PMID:12049028

Home treatment for mental health problems: a systematic review. [Health Technol Assess. 2001]

PMID:11532236

[Diagnostic structured interviews in child and adolescent's psychiatry] [Encephale. 2004]

PMID:15107714

[Acute psychiatric day hospital treatment: is the effectiveness of this treatment approach still questionable?] [Psychiatr Prax. 2004]

PMID:15546056

1: Soc Psychiatry Psychiatr Epidemiol. 2005 Dec;40(12):1019-24.

49. Validation study of a nonspecific psychological distress scale.

Poulin C, Lemoine O, Poirier LR, Lambert J.

Montreal Public Health Department, Agence des reseaux locaux de services de sante et de services sociaux, Montreal, QC, Canada. cpoulin@santepub-mtl.qc.ca

BACKGROUND: Psychological distress scales are often used in national epidemiological surveys to monitor the mental health status and predict demands in mental health services. These scales have the advantage of being easy to administer and inexpensive to use. The goal of this study is to assess the clinical validity of the Psychological Distress Manifestations Measure Scale (PDMMS) by comparing it to a standard criterion. METHOD: The validation study is based on data from a large-scale mental health survey conducted in 1999 in the Montreal area (Canada). The target population was constituted of adults living in private households. A telephone survey was carried out with a probability sample of 4,704 respondents using the Composite International Diagnostic Interview Simplified (CIDIS) to detect mental disorders. Then, subsequent face-to-face interviews with a subsample of 359 of these respondents were conducted to validate other measures for assessing mental health needs

for care and services including the PDMMS. RESULTS: Our study showed that high psychological distress is highly associated with mental disorder (OR=5.94). However, a large majority of the people in the high psychological distress category does not have a known mental problem. CONCLUSIONS: These data confirm that like other psychological distress scales, the PDMMS is not a diagnostic tool. Rather, it is designed to explore comorbidity among symptoms, independent of caseness. The prevalence of psychological distress in the population allows us to identify people who have subclinical symptoms substantial enough to precipitate dysfunctioning in everyday life and who utilize health services more frequently. The use of this tool for epidemiological surveys is useful for mental health service planning because it provides information on the needs of individuals whose state of mental health affects social functioning even though they do not suffer from pathology.

PMID: 16215656 [PubMed - indexed for MEDLINE]

Related Links

Short screening scales to monitor population prevalences and trends in non-specific psychological distress. [Psychol Med. 2002]

PMID:12214795

Telephone surveys as an alternative for estimating prevalence of mental disorders and service utilization: a Montreal catchment area study. [Can J Psychiatry. 1997]

PMID:9307834

[Study on psychiatric disorders and defensive process assessed by the "defense style questionnaire" in sterile males SAMPLE consulting in andrology] [Encephale. 2005]

PMID:16389709

[Evaluation and validation of a test of psychological distress in a general population in french Quebec] [Can J Public Health. 1998]

PMID:9654804

[Methodology of a study on insomnia in the general population] [Encephale. 2002]

PMID:12091782

1: Aust N Z J Psychiatry. 2006 Aug;40(8):623-31.

50. Do older Australians truly have low rates of anxiety and depression? A critique of the 1997 National Survey of Mental Health and Wellbeing.

O'Connor DW.

Department of Psychological Medicine, Monash University, Kingston Centre, Warrigal Road, Cheltenham, Victoria 3192, Australia. daniel.oconnor@med.monash.edu.au

This paper sets out to critically evaluate reports from the Australian-wide National Survey of Mental Health and Wellbeing of very low rates of ICD-10 anxiety and depressive disorders in community resident older Australians. Data from the National Survey, which relied on the Composite International Diagnostic Interview (CIDI) were re-computed and re-analysed to address concerns about population sampling, interview response patterns and alternate measures of mental health. Rates of anxiety and depressive disorders fell to low levels after 65 years and continued to fall thereafter. This is at odds with findings from gerontological surveys that used assessment tools better suited to frail older people. Scores on mental health scales, together with diagnostic algorithms that obviated CIDI skip patterns, showed much less change in mental wellbeing across generations. It is argued that sampling and case ascertainment bias combined to reduce rates of anxiety and depression in very old people, especially when adjustments are made for the high morbidity levels encountered in aged residential facilities. Functional mental disorders almost certainly rise in frequency in advanced old age, often in conjunction with dementia.

PMID: 16866757 [PubMed - indexed for MEDLINE]

Related Links

Non-disabled cases in a national survey. [Psychol Med. 2001] PMID:11459375

DSM-IV generalized anxiety disorder in the Australian National Survey of Mental Health and Well-Being. [Psychol Med. 2002]

PMID:12102379

A National Depression Index for Australia. [Med J Aust. 2004]

PMID:15462643

Is the Australian National Survey of Mental Health and Wellbeing a reliable guide for health planners? A methodological note on the prevalence of depression. [Aust N Z J Psychiatry. 2004]

PMID:15298586

A general population comparison of the Composite International Diagnostic Interview (CIDI) and the Schedules for Clinical Assessment in Neuropsychiatry (SCAN). [Psychol Med. 2001]

PMID:11513368

1: Psychol Med. 2001 Aug;31(6):1001-13.

51. A general population comparison of the Composite International Diagnostic Interview (CIDI) and the Schedules for Clinical Assessment in Neuropsychiatry (SCAN).

Brugha TS, Jenkins R, Taub N, Meltzer H, Bebbington PE.

Department of Psychiatry, University of Leicester.

BACKGROUND: In psychiatric surveys of the general population, there has been considerable discrepancy between diagnoses obtained by fully structured interviews and those established by systematic semi-structured clinical evaluation. The Composite International Diagnostic Interview (CIDI) is an example of the first type of interview widely used in general population surveys. We compared its performance in diagnosing current depressive and anxiety disorders with the Schedules for Clinical Assessment in Neuropsychiatry (SCAN), a semi-structured diagnostic interview administered by clinically trained interviewers. METHODS: Household addresses in Leicestershire, UK, were randomly sampled and 860 adults were screened with the Revised Clinical Interview Schedule. Adults with too few symptoms to fulfil diagnostic criteria for study disorders were excluded to increase the proportion re-interviewed who met such criteria. Repeat diagnostic interviews with the CIDI and SCAN, ordered randomly, were sought from eligible screen positive respondents. Recalibrated CIDI prevalence estimates were derived from the SCAN classification using Bayesian statistics. RESULTS: Concordance ranged between 'poor' and 'fair' across almost all types of study disorders, and for co-morbidity. Concordance was somewhat better for severity of depression and when lower diagnostic thresholds were used for depression. Interview order effects were suggested with lower concordance when CIDI followed SCAN. Recalibration reduced the prevalence of depressive or anxiety disorder from 9.0 to 6.2%. CONCLUSIONS: Community psychiatric surveys using structured diagnostic interview data must be interpreted cautiously. They should include an element of clinical re-appraisal so findings can be adjusted for estimation differences between fully structured and clinical assessments.

PMID: 11513368 [PubMed - indexed for MEDLINE]

Related Links

A comparison of two structured diagnostic interviews: CIDI and SCAN. [Aust N Z J Psychiatry. 1995]

PMID:7625961

[Diagnostic structured interviews in child and adolescent's psychiatry] [Encephale. 2004]

PMID:15107714

Validation of two survey diagnostic interviews among primary care attendees: a comparison of CIS-R and CIDI with SCAN ICD-10 diagnostic categories. [Psychol Med. 2004]

PMID:15554572

Major depressive episode among young adults: CIDI-SF versus SCAN consensus diagnoses. [Psychol Med. 2002]

PMID:12420900

Cross validation of a general population survey diagnostic interview: a comparison of CIS-R with SCAN ICD-10 diagnostic categories. [Psychol Med. 1999]

PMID:10576296

1: Clin Pract Epidemol Ment Health. 2006 Nov 29;2:33.

52. Validation of the Edinburgh postpartum depression scale in a population of puerperal women in Mexico.

Alvarado-Esquivel C, Sifuentes-Alvarez A, Salas-Martinez C, Martinez-Garcia S.

Facultad de Medicina, Universidad Juarez del Estado de Durango, Durango, Dgo, Mexico. alvaradocosme@yahoo.com.

ABSTRACT: BACKGROUND: The Edinburgh postnatal depression scale (EPDS) has been validated and used successfully in detecting postnatal depression in several language versions in a number of countries. However, there is not any Mexican version of the EPDS that had been validated. Therefore, we sought to validate a Spanish translated Mexican version of the EPDS in a population of puerperal Mexican women. METHODS: One hundred puerperal women within their three month postpartum period attending routine postnatal consultations in a public hospital in Durango City, Mexico participated in the study. The participants were divided into two groups: one group included 49 women with less than 4 weeks of postpartum, and the other group included 51 women within 4 to 13 weeks of postpartum. All participants submitted a Spanish translated Mexican version of the EPDS and were interviewed by a psychiatrist to assess major and minor depression by using DSM-IV criteria. RESULTS: Out of the 49 women with less than 4 weeks of postpartum, 4 were found as suffering from major depression and none from minor depression by using the DSM-IV criteria. In this group of women we found that the best EPDS score for screening depression was 11/12. This threshold showed a sensitivity of 75% (95% CI: 63.8-86.2), a specificity of 93% (95% CI: 84.6-100), a positive predictive value of 50%, a negative predictive value of 97.6%, and an area under the curve of 0.84. While in the 51 women within 4 to 13 weeks of postpartum, 7 were

found as suffering from major depression and 1 from minor depression by using the DSM-IV criteria. In this group we found that the best EPDS score for screening depression was 7/8. This threshold showed a sensitivity of 75% (95% CI: 66.1-83.9), a specificity of 84% (95% CI: 76.1-91.9), a positive predictive value of 46.2%, a negative predictive value of 94.7% and an area under the curve of 0.80. CONCLUSION: The Mexican version of the EPDS can be considered for screening depression in puerperal Mexican women whenever cut-off scores of 11/12 and 7/8 in women with less than 4 weeks and within 4 to 13 weeks of postpartum are used, respectively.

PMID: 17134495 [PubMed - in process]

Related Links

Validation of the Thai Edinburgh Postnatal Depression Scale for screening postpartum depression. [Psychiatry Res. 2007]

PMID:17084907

Validation of the Edinburgh Postnatal Depression Scale (EPDS) in Spanish mothers. [J Affect Disord. 2003]

PMID:12781353

[A study of the Edinburgh Postnatal Depression Scale (EPDS) on 859 mothers: detection of mothers at risk for postpartum depression] [Encephale. 2004]

PMID:15538313

[Validation of a Spanish version of the Edinburgh Postnatal Depression Scale] [Actas Esp Psiquiatr. 2002]

PMID:12028943

Validation of the Edinburgh Postnatal Depression Scale on a cohort of South African women. [S Afr Med J. 1998]

PMID:9807193

1: Psychol Assess. 2005 Mar;17(1):110-4.

53. Validation of the Beck Depression Inventory-II in a low-income African American sample of medical outpatients.

Grothe KB, Dutton GR, Jones GN, Bodenlos J, Ancona M, Brantley PJ.

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The psychometric properties of the Beck Depression Inventory-II (BDI-II) are well established with primarily Caucasian samples. However, little is known about its reliability and validity with minority groups. This study evaluated the psychometric properties of the BDI-II in a sample of low-

income African American medical outpatients (N=220). Reliability was demonstrated with high internal consistency (.90) and good item-total intercorrelations. Criterion-related validity was demonstrated. A confirmatory factor analysis supported a hierarchical factor structure in which the BDI-II reflected 2 first-order factors (Cognitive and Somatic) that in turn reflected a second-order factor (Depression). These results are consistent with previous findings and thus support the use of the BDI-II in assessing depressive symptoms for African American patients in a medical setting.

PMID: 15769232 [PubMed - indexed for MEDLINE]

Related Links

Psychometric properties of a Persian-language version of the Beck Depression Inventory--Second edition: BDI-II-PERSIAN. [Depress Anxiety. 2005]

PMID:16075452

Reliability and validity of the Beck depression inventory--II with adolescent psychiatric inpatients. [Psychol Assess. 2004]

PMID:15222808

Cross-cultural validation of the Beck Depression Inventory-II in Japan. [Psychiatry Res. 2002]

PMID:12127479

Factorial invariance of the CES-D in low socioeconomic status African Americans compared with a nationally representative sample. [Psychiatry Res. 2004]

PMID:15123397

Factor structure, concurrent validity, and internal consistency of the Beck Depression Inventory-Second Edition in a sample of college students. [Depress Anxiety. 2004]

PMID:15129421

1: Psychiatry Res. 2002 Jul 31;110(3):291-9.

54. Cross-cultural validation of the Beck Depression Inventory-II in Japan.

Kojima M, Furukawa TA, Takahashi H, Kawai M, Nagaya T, Tokudome S.

Department of Health Promotion and Disease Prevention Nagoya City University Graduate School of Medicine, Kawasumi 1, Mizuho-cho, Mizuho-Ku, Nagoya, Japan, 467-8601. masayok@med.nagoya-cu.ac.jp

The Beck Depression Inventory has undergone substantial revision recently as the BDI-II to correspond to DSM-IV criteria. We developed the Japanese version of the BDI-II and examined its psychometric properties. The linguistic equivalence was verified by a back-translation method. The

final translation was administered to the visitors at a public health care center, and the responses of 766 adults (age = 24-82 years, women = 40%) were analyzed. Half of the participants completed the Center for Epidemiologic Studies Depression Scale (CES-D) as well. A high level of internal consistency reliability (Cronbach's alpha = 0.87) and item homogeneity was confirmed. Exploratory factor analysis showed a two-factor structure (cognitive and somatic-affective), which was almost identical to the original model demonstrated by Beck et al. (1996, Manual for the Beck Depression Inventor Psychological Corporation, San Antonio, TX, USA). The following confirmatory factor analysis also supported the two-factor structure. Adequate correlation ($r = 0.69$, $P < 0.001$) between the total score of the BDI-II and that of the CES-D was observed. A higher score for women compared to men, without significant age differences, was consistent with the results of previous reports. We conclude that the Japanese version of the BDI-II is psychometrically robust and can be used to assess depressive symptoms in Japanese people.

PMID: 12127479 [PubMed - indexed for MEDLINE]

Related Links

Psychometric properties of a Persian-language version of the Beck Depression Inventory--Second edition: BDI-II-PERSIAN. [Depress Anxiety. 2005]

PMID:16075452

[Reliability and validity of the Japanese version of the coping inventory for stressful situations (CISS): a contribution to the cross-cultural studies of coping] [Seishin Shinkeigaku Zasshi. 1993]

PMID:8234537

Factor structure, concurrent validity, and internal consistency of the Beck Depression Inventory-Second Edition in a sample of college students. [Depress Anxiety. 2004]

PMID:15129421

[The Fear of Negative Evaluation scale (FNE): psychometric properties of the French version.] [Encephale. 2004]

PMID:15738853

[Validation of the French version of the Body Shape Questionnaire] [Encephale. 2005]

PMID:15959443

1: Dement Geriatr Cogn Disord. 2004;17(1-2):35-41. Epub 2003 Oct 13.

55. Different classification systems yield different dementia occurrence among nonagenarians and centenarians.

Pioggiosi P, Forti P, Ravaglia G, Berardi D, Ferrari G, De Ronchi D.

Institute of Psychiatry, University of Bologna, Bologna, Italy.

Literature data consistently show different prevalence estimates of dementia when different classification systems are used in the same population. Very few data are available for the oldest old of the elderly. We investigated the occurrence of dementia among 34 nonagenarians and centenarians according to four classification systems: the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders, third edition revised (DSM-III-R) and fourth edition (DSM-IV), the World Health Organization's International Classification of Diseases, 10th revision (ICD-10), and the Cambridge Examination for Mental Disorders of the Elderly (CAMDEX). Cognitive functioning, work, social function and independence in activities of daily living were evaluated by using an extensive neuropsychological examination. The prevalence (95% CI) of dementia was the following: 47.1% (95% CI 30.3-63.8) with the DSM-III-R criteria, 41.2% (95% CI 24.6-57.7) with the DSM-IV criteria, 29.4% (95% CI 14.1-44.7) with the ICD-10 criteria and 38.2% (95% CI 21.9-54.6) with the CAMDEX. The factors that best predicted disagreement between DSM-III-R and DSM-IV were calculation impairment and the presence or absence of personality changes. DSM-III-R and ICD-10 were differentiated by the weight given to executive functions that all have to be impaired according to ICD-10, whereas progressive deterioration differentiated CAMDEX from DSM-III-R. It should be noted that although the DSM-III-R diagnoses differ by a factor of 1.6 times from the ICD-10 and 1.2 times from the CAMDEX diagnoses, we are speaking about dementia, which is very frequent in nonagenarians and centenarians. Moreover, with regard to public health, an estimation of the number of subjects who will lose their autonomy is rather more useful and informative than simple prevalence figures of dementia by itself. In this light, classification systems, such as the ICD-10, that do not include impairment of social function as a criterion for assessing dementia become less adequate. Copyright 2004 S. Karger AG, Basel

PMID: 14560063 [PubMed - indexed for MEDLINE]

Related Links

The effect of different diagnostic criteria on the prevalence of dementia. [N Engl J Med. 1997]

PMID:9385127

Comparison of different clinical criteria (DSM-III, ADDTC, ICD-10, NINDS-AIREN, DSM-IV) for the diagnosis of vascular dementia. National Institute

of Neurological Disorders and Stroke-Association Internationale pour la Recherche et l'Enseignement en Neurosciences. [Stroke. 2000]

PMID:11108755

A new systematic method of measurement and diagnosis of "mild cognitive impairment" and dementia according to ICD-10 and DSM-III-R criteria. [Int Psychogeriatr. 1992]

PMID:1288663

Comparison of different clinical diagnostic criteria for depression in Alzheimer disease. [Am J Geriatr Psychiatry. 2006]

PMID:16816012

Prevalence of dementia in a rural Netherlands population and the influence of DSM-III-R and CAMDEX criteria for the prevalence of mild and more severe forms. [J Clin Epidemiol. 1998]

PMID:9495684

1: Am J Geriatr Psychiatry. 2006 Jul;14(7):589-97.

56. Comparison of different clinical diagnostic criteria for depression in Alzheimer disease.

Vilalta-Franch J, Garre-Olmo J, Lopez-Pousa S, Turon-Estrada A, Lozano-Gallego M, Hernandez-Ferrandiz M, Pericot-Nierga I, Feijoo-Lorza R.

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OBJECTIVE: Data in the literature show different estimates of the prevalence of depression in patients with Alzheimer disease (AD) when different classification systems are used. This study describes the prevalence and clinical features of depression in AD based on five different depression classification systems.

METHODS: This was a cross-sectional, observational study of 491 patients with probable AD. Depression was diagnosed using five classification systems (International Classification of Diseases, 10th Revision [ICD-10], Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition [DSM-IV], Cambridge Examination for Mental Disorder of the Elderly [CAMDEX], Provisional Diagnostic Criteria for depression in AD [PDC-dAD], Neuropsychiatric Inventory [NPI]).

RESULTS: The prevalence of depression was 4.9% (95% confidence interval [CI]: 3.2-7.1) according to ICD-10 criteria; 9.8% (95% CI: 7.3-12.6) according to CAMDEX; 13.4% (95% CI: 10.6-16.6) according to DSM-IV; 27.4% (95% CI: 23.6-31.5) according to PDC-dAD criteria; and 43.7% (95% CI: 39.4-48.2) when using the screening questions from the NPI depression subscale. The level of agreement between the

classification systems was low to moderate (kappa <0.52). The characteristics associated with the most diagnostic disagreement were loss of confidence or self-esteem and irritability.

CONCLUSIONS: This study shows that there is a high variability in the prevalence rates of depression in AD depending on the diagnostic criteria used and that there is a low rate of agreement among the diagnostic criteria analyzed. The results suggest that the use of generic diagnostic criteria such as the ICD-10, the CAMDEX, or DSM-IV provides low prevalence rates of depression in patients with AD compared with specific diagnostic criteria such as the PDC-dAD.

PMID: 16816012 [PubMed - indexed for MEDLINE]

Related Links

Different classification systems yield different dementia occurrence among nonagenarians and centenarians. [Dement Geriatr Cogn Disord. 2004]

PMID:14560063

Neuropsychiatric symptoms in Alzheimer disease and cognitively impaired, nondemented elderly from a community-based sample in Brazil: prevalence and relationship with dementia severity. [Am J Geriatr Psychiatry. 2006]

PMID:16670248

[Validation of the Short Cognitive Battery (B2C). Value in screening for Alzheimer's disease and depressive disorders in psychiatric practice] [Encephale. 2003]

PMID:12876552

Short versions of the geriatric depression scale: a study of their validity for the diagnosis of a major depressive episode according to ICD-10 and DSM-IV. [Int J Geriatr Psychiatry. 1999]

PMID:10521885

Comparison of different clinical criteria (DSM-III, ADDTC, ICD-10, NINDS-AIREN, DSM-IV) for the diagnosis of vascular dementia. National Institute of Neurological Disorders and Stroke-Association Internationale pour la Recherche et l'Enseignement en Neurosciences. [Stroke. 2000]

PMID:11108755

1: N Engl J Med. 1997 Dec 4;337(23):1667-74.

57. The effect of different diagnostic criteria on the prevalence of dementia.

Erkinjuntti T, Ostbye T, Steenhuis R, Hachinski V.

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BACKGROUND: There are several widely used sets of criteria for the diagnosis of dementia, but little is known about their degree of agreement and their effects on estimates of the prevalence of dementia. METHODS: We examined 1879 men and women 65 years of age or older who were enrolled in the Canadian Study of Health and Aging and calculated the proportion given a diagnosis of dementia according to six commonly used classification systems: the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders (DSM), third edition (DSM-III), the third edition, revised of the DSM (DSM-III-R), the fourth edition of the DSM (DSM-IV), the World Health Organization's International Classification of Diseases (ICD), 9th revision (ICD-9) and 10th revision (ICD-10), and the Cambridge Examination for Mental Disorders of the Elderly (CAMDEX). The degree of concordance among classification schemes and the importance of various factors in determining diagnostic agreement or disagreement were examined. RESULTS: The proportion of subjects with dementia varied from 3.1 percent when we used the criteria of the ICD-10 to 29.1 percent when the DSM-III criteria were used. The six classification systems identified different groups of subjects as having dementia; only 20 subjects were given a diagnosis of dementia according to all six systems. The classifications based on the various systems differed little according to the patients' age, sex, educational level, or status with respect to institutionalization. The factors that most often caused disagreement in diagnosis between DSM-III and ICD-10 were long-term memory, executive function, social activities, and duration of symptoms. CONCLUSIONS: The commonly used criteria for diagnosis can differ by a factor of 10 in the number of subjects classified as having dementia. Such disagreement has serious implications for research and treatment, as well as for the right of many older persons to drive, make a will, and handle financial affairs.

PMID: 9385127 [PubMed - indexed for MEDLINE]

Related Links

Different classification systems yield different dementia occurrence among nonagenarians and centenarians. [Dement Geriatr Cogn Disord. 2004]

PMID:14560063

Comparison of different clinical criteria (DSM-III, ADDTC, ICD-10, NINDS-AIREN, DSM-IV) for the diagnosis of vascular dementia. National Institute of Neurological Disorders and Stroke-Association Internationale pour la Recherche et l'Enseignement en Neurosciences. [Stroke. 2000]

PMID:11108755

Dementia three months after stroke. Baseline frequency and effect of different definitions of dementia in the Helsinki Stroke Aging Memory Study (SAM) cohort. [Stroke. 1997]

PMID:9099197

Prevalence of dementia in a rural Netherlands population and the influence of DSM-III-R and CAMDEX criteria for the prevalence of mild and more severe forms. [J Clin Epidemiol. 1998]

PMID:9495684

The impact of different diagnostic criteria on prevalence rates for delirium. [Dement Geriatr Cogn Disord. 2003]

PMID:12826742

58. Common mental disorders in postconflict settings.

1: Lancet. 2003 Jun 21;361(9375):2128-30.

de Jong JT, Komproe IH, Van Ommeren M.

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Research into postconflict psychiatric sequelae in low-income countries has been focused largely on symptoms rather than on full psychiatric diagnostic assessment. We assessed 3048 respondents from postconflict communities in Algeria, Cambodia, Ethiopia, and Palestine with the aim of establishing the prevalence of mood disorder, somatoform disorder, post-traumatic stress disorder (PTSD), and other anxiety disorders. PTSD and other anxiety disorders were the most frequent problems. In three countries, PTSD was the most likely disorder in individuals exposed to violence associated with armed conflict, but such violence was a common risk factor for various disorders and comorbidity combinations in different settings. In three countries, anxiety disorder was reported most in people who had not been exposed to such violence. Experience of violence associated with armed conflict was associated with higher rates of disorder that ranged from a risk ratio of 2.10 (95% CI 1.38-2.85) for anxiety in Algeria to 10.03 (5.26-16.65) for PTSD in Palestine. Postconflict mental health programmes should address a range of common disorders beyond PTSD.

PMID: 12826440 [PubMed - indexed for MEDLINE]

Related Links

Lifetime events and posttraumatic stress disorder in 4 postconflict settings. [JAMA. 2001]

PMID:11476657

Epidemiology of trauma, post-traumatic stress disorder (PTSD) and co-morbid disorders in Chile. [Psychol Med. 2006]

PMID:16854253

Longitudinal course of posttraumatic stress disorder and posttraumatic stress disorder symptoms in a community sample of adolescents and young adults. [Am J Psychiatry. 2005]

PMID:15994715

Traumatic events and post-traumatic stress disorder in the community: prevalence, risk factors and comorbidity. [Acta Psychiatr Scand. 2000]

PMID:10674950

Posttraumatic stress disorder and comorbidity: recognizing the many faces of PTSD. [J Clin Psychiatry. 1997]

PMID:9329446

59. Psychiatric disability among tortured Bhutanese refugees in Nepal.

1: Am J Psychiatry. 2003 Nov;160(11):2032-7.

Thapa SB, Van Ommeren M, Sharma B, de Jong JT, Hauff E.

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OBJECTIVE: Most refugees live in low-income countries. There is a lack of data on psychiatric disability among such refugees. The authors compared psychiatric disability in tortured and nontortured Bhutanese refugees living in Nepal and examined factors associated with psychiatric disability among the tortured refugees. METHOD: A cross-sectional survey was conducted among 418 tortured and 392 nontortured Bhutanese refugees, matched for age and gender. The Composite International Diagnostic Interview, version 2.1, and the World Health Organization Short Disability Assessment Schedule were used to measure ICD-10 psychiatric disorders and disability, respectively. RESULTS: Approximately one in five tortured and nontortured Bhutanese refugees were found to be disabled. Posttraumatic stress disorder, specific phobia, and present physical disease were identified as factors associated with disability among the tortured refugees. On the other hand, present physical disease, greater age, and generalized anxiety disorder were associated with disability among the nontortured group. CONCLUSIONS: These findings show that the tortured and nontortured refugees were equally likely to be disabled. Different sets of predictors were identified among tortured and nontortured refugees, indicating the need for comprehensive psychiatric assessment of both tortured and nontortured refugees in clinical practice.

Publication Types: Comparative Study

PMID: 14594752 [PubMed - indexed for MEDLINE]

60. Psychological and psychopathological reactions in Honduras following Hurricane Mitch: implications for service planning.

1: Rev Panam Salud Publica. 2005 Oct-Nov;18(4-5):287-95.

Psychological and psychopathological reactions in Honduras following HurricaneMitch: implications for service planning.

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BACKGROUND: Posttraumatic stress disorder (PTSD) and other psychopathological outcomes have not been sufficiently studied in community-based samples in Latin America. This study explored various psychopathological reactions and their respective risk factors two months after Hurricane Mitch struck Honduras in October 1998. METHODS: In the Honduran capital of Tegucigalpa, 800 respondents age 15 and older were selected from residential areas of high, middle, or low socioeconomic status that had suffered either high or low impact from the devastating effects of the hurricane. The Composite International Diagnostic Interview was used to diagnose PTSD. Depression, alcohol misuse, and grief reaction were examined using screening instruments, and the Self-Reporting Questionnaire was used to measure demoralization. The Impact of Event Scale was administered to ascertain the severity of the posttraumatic reaction.

RESULTS: PTSD was present in 10.6% of the sample. Respondents from the high-impact residential areas were more distressed, had higher scores on the grief inventory, and showed greater severity in PTSD symptoms. The respondents from the high-impact residential areas also had higher prevalence rates of major depression, alcoholism, and prior emotional problems. The best explanatory model for the risk of developing PTSD included the degree of exposure based on reported traumatic events, and associated increased demoralization. Among the persons with PTSD, its severity was predicted by being female and by the degree of exposure to hurricane-related traumatic events. CONCLUSIONS: Out of a total population of 3.3 million adults (age 15 and older) in Honduras, it is estimated that over 492,000 of them may have developed PTSD due to Hurricane Mitch. Adequate health disaster preparedness and response requires full acknowledgementof the multiple psychological effects that victims experience.

PMID: 16354426 [PubMed - indexed for MEDLINE]

Related Links

Prevalence, risk factors and aging vulnerability for psychopathology following a natural disaster in a developing country. [Int J Geriatr Psychiatry. 2005]

PMID:16116578

Psychological impact of the hurricane Mitch in Nicaragua in a one-year perspective. [Soc Psychiatry Psychiatr Epidemiol. 2001]

PMID:11465781

Posttraumatic stress and depressive reactions among Nicaraguan adolescents after hurricane Mitch. [Am J Psychiatry. 2001]

PMID:11329403

[Prospective study of post-traumatic stress in victims of terrorist attacks] [Encephale. 2001]

PMID:11760689

Posttraumatic stress symptoms, intrusive thoughts, loss, and immune function after Hurricane Andrew. [Psychosom Med. 1997]

PMID:9088048

61. Psychiatric morbidity among Afghan refugees in Peshawar, Pakistan.

1: J Ayub Med Coll Abbottabad. 2005 Apr-Jun;17(2):23-5.

Naeem F, Mufti KA, Ayub M, Haroon A, Saifi F, Qureshi SM, Ihsan A, Chaudry HR, Dagarwal SR, Kingdon D.

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BACKGROUND: A review of the literature shows that refugees in different parts of the world have high rates of psychological and emotional problems. However, psychiatric morbidity among Afghan refugees in Pakistan has been poorly studied. Most of the studies of psychiatric disorders come from western countries. However, these studies may not be representative of the Afghan refugees in Pakistan. This study was carried out to measure psychiatric morbidity among a group of Afghan refugees attending a psychiatric clinic in Peshawar, Pakistan.

METHODS: This is a cross sectional study, to measure prevalence of psychiatric morbidity among the residents of Afghan refugee camps in Peshawar, Pakistan, who attended a psychiatric clinic between November 2003 and February 2004. Data were collected using Mini International neuropsychiatry Interview Schedule (MINI), and a form specifically developed for the study. RESULTS: Nearly 80% of our patients had a diagnosis of Post Traumatic Stress Disorder. Nearly half (47.9%) reported family history of mental illness, while almost a quarter (23.3%) had a physical disability or long term illness. Only 13.7% (106) had contacted

health services prior to seeking help for their psychiatric illness. CONCLUSIONS: A high number of patients presenting with PTSD is not an unusual finding when one considers the traumatic experiences faced by the general population of Afghanistan. Only a small number of the patients had been in contact with the health services prior to their contact with the psychiatric service. This study highlights the importance of health education among Afghan refugees and to establish the mental health services for them.

PMID: 16092644 [PubMed - indexed for MEDLINE]

Related Links

[Many psychiatric disorders in Afghan refugees with residential status in Drenthe, especially depressive disorder and post-traumatic stress disorder] [Ned Tijdschr Geneeskd. 2002]

PMID:12092304

Nutritional and mental health status of Afghan refugee children in Peshawar, Pakistan: a descriptive study. [Asia Pac J Public Health. 2005]

PMID:16425652

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PMID:9701081

Psychiatric problems in an Afghan village. [J Ayub Med Coll Abbottabad. 2005]

PMID:16320789

Size and sociodemographic characteristics of the Afghan refugee population in Pakistan. [J Biosoc Sci. 1990]

PMID:2169475

Edición
Secretaría de Ciencia y Técnica
Ciudad Autónoma de Buenos Aires
Argentina
Diciembre 2008