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Asking patients about their general level of functioning: Is IT worth IT for common mental disorders?

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ABSTRACT

Functional disability (FD) is a diagnostic criterion for the psychiatric diagnosis of many mental disorders (e.g. generalized anxiety disorder (GAD); major depressive episode (MDE)). We aimed to assess the contribution of measuring FD to diagnosing GAD and MDE using clinical (Global Assessment of Functioning, GAF) and self-reported methods (Analog scale of functioning, ASF and World Health Organization Disability Assessment Schedule WHODAS 2.0). Patients seeking professional help for mood/anxiety symptoms ($N=244$) were evaluated. The MINI interview was used to determine the presence of common mental disorders. Symptoms were assessed with two short checklists. Logistic and hierarchical logistic models were used to determine the diagnostic accuracy and the added diagnostic value of FD assessment in detecting GAD and MDE. For GAD, FD alone had a diagnostic accuracy of 0.79 (GAF), 0.79 (ASF) and 0.78 (WHODAS) and for MDE of 0.83, 0.84 and 0.81, respectively. Self-reported measures of FD improved the diagnostic performance of the number of symptoms (4% AUC increase) for GAD, but not for MDE. If assessed before symptom evaluation, FD can discriminate well between patients with and without GAD/MDE. When assessed together with symptoms, self-reported methods improve GAD detection rates.

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1. Introduction

Mood and anxiety disorders are commonly seen in Primary Care (Terluin et al., 2009). Prevalence levels of depression and anxiety vary in this setting from 3% to 29% and from 1% to 23%, respectively according to a multicenter WHO study (Goldberg and Lecrubier, 1995). They are highly prevalent and have a negative effect on quality of life causing considerable functional disability (Olfson et al., 1997) and subsequently important personal, social and economic losses (McKnight and Kashdan, 2009). Thus, the evaluation of functional disability is essential for treatment planning (McQuaid et al., 2012) and monitoring clinical progress (Niv et al., 2007), being at the same time an important treatment outcome (Brown et al., 2014).

Many instruments, both clinical and self-reported have been developed over the years for the assessment of mental disorders' symptoms in clinical practice (Olariu et al., 2014). This contrasts with the assessment of functional disability where fewer instruments are available and where clinician ratings are the preferred method of assessment. Arguably, the most important instrument for evaluating change in psychiatric functioning has been the Global Assessment of Functioning (GAF) (Vatnaland et al., 2007; Pedersen and Karterud, 2012). The GAF was included in the DSM-IV and was proposed as the standard diagnostic assessment of functional disability in psychiatry (Hall, 1995; Sohail et al., 2013), reflecting the clinician's judgment of a patient's overall level of psychological, social and occupational functioning (Söderberg et al., 2005). It provides a good clinical overview with good reliability in research settings (Russell et al., 1979; Mezzich et al., 1985; Rey et al., 1988; Hilsenroth et al., 2000; Beitchman et al., 2001; Startup et al., 2002; Haro et al., 2003; Söderberg et al., 2005; Niv et al., 2007; Pedersen et al., 2007). In spite of its simplicity (Startup et al., 2002; Urbanoski et al., 2014) and focus on the quality of life of psychiatric patients (Dimsdale et al., 2010), the GAF has been criticized for having low inter-rater reliability in routine clinical settings (Vatnaland et al., 2007) and for failing to

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capture the complexities of functioning disability in psychiatric patients (Aas, 2010; Gold, 2014). Notwithstanding, a major criticism has been that is sensitive to symptom severity (Hilsenroth et al., 2000; Söderberg et al., 2005; Smith et al., 2011; Von Korff et al., 2011) to a higher degree than it is to impairment. As an alternative, patient-reported outcomes (PROs) have been proposed as measures of change in health status and treatment efficacy (Kulnik and Nikoletou, 2014) and have been included as the standard for routine clinical evaluations of disability in the recent DSM-5 (American Psychiatric Association, 2013). More specifically, the American Psychiatric Association, through the issue of DSM-5, adhered to the International Classification of Functioning, Disability and Health (ICF) (World Health Organization, 2001; Ustün et al., 2003) in order to converge with international standards. In the ICF, functioning is understood as a dynamic interaction between health, environment and personal factors. Functioning and disability depend on symptoms, but they are not symptoms, being conceptualized as impairments in body functions and structures, limitations in activities and restriction in participation. Importantly, a health condition must always be present when ICF is applied.

In accordance with the ICF, DSM 5 proposes using the World Health Organization Disability Scale 2.0 (WHODAS 2.0) (Ustün et al., 2010a) as the standard for assessing disability. WHODAS 2.0 has good psychometric properties (Federici et al., 2009) tested in patients with diverse physical and mental conditions (Chwastiak and Von Korff, 2003; Chisolm et al., 2005; Baron et al., 2008; Luciano et al., 2010b) in culturally diverse countries. It is short, simple and easy to administer, and it can be used across physical and mental conditions to generate standardized disability levels and profiles in both clinical and general population settings.

Besides WHODAS 2.0, other self-reported instruments of functioning disability have been developed. They are based on patients' responses of the GAF and are more sensitive to treatment effects than observer rating-scales (Kellner et al., 1979), just like any other self-rating procedure. Additionally, they have been found to have acceptable validity and reliability between patients' and experts' ratings (Bodlund et al., 1994; Ramirez et al., 2008).

The criterion of clinically significant distress or impairment is necessary for the psychiatric diagnosis of many mental disorders (Konecky et al., 2014). Hence, standard systems, such as the DSM, include the evaluation of patient functioning as part of the compulsory criteria for establishing an active disorder. Even though the latest edition of the DSM has brought substantial change in the method of assessment of functional disability, little information exists about the contribution of clinical and self-reported data on functional disability in the diagnostic process.

The objective of this study was to assess the relative contribution of clinical and self-reported functional disability measures to the diagnosis of GAD and MDE, in terms of concordance with a final diagnosis made with consensus methods. We also aimed to compare the contribution of measuring functional disability in addition to evaluating symptoms, when diagnosing generalized anxiety disorder (GAD) and major depressive episode (MDE). Our main hypothesis was that functional disability yields good discriminatory ability to detect positive cases regardless of the method of assessment. Our second hypothesis was that the contribution of functional disability would be subsidiary to symptomatology information, as indicated by a marginal increase in the predictive ability when included in the assessment in addition to symptoms. As a final hypothesis we expected that self-reported measures of functional disability would have similar diagnostic ability as clinician-reported measures.

2. Methods

2.1. Design

Prospective study (baseline, 1-month, 3-months assessments) with a convenience sample of patients who sought professional help for mood and anxiety disorders symptoms. Patients came from three different health-care levels: primary care, outpatient mental health centers and acute psychiatric inpatient facilities/hospitals. The study protocol was revised and approved by the Ethics committee from Hospital del Mar Medical Research Institute (IMIM) and was carried out in accordance with the principles of the Declaration of Helsinki.

2.2. Sample

Health-care professionals from collaborating health-care centers invited patients to participate in our study according to the following inclusion criteria: adults older than 18 years old seeking care for affective symptomatology. Patients were excluded if they presented psychotic symptoms, syndromes attributable to organic or substance origin, or significant cognitive impairment. Further details on recruitment have been published elsewhere (Olariu et al., 2014).

2.3. Data collection

Certified clinical psychologists, all of them with four years of postgraduate formal hospital internships as required by the Spanish health system, conducted the interviews. The clinical psychology residency program includes, among others, formal instruction in psychiatric diagnosis according to DSM and ICD systems, in differential diagnosis and in the use of assessment procedures and instruments, such as the SCID, the CIDI and the MINI. It also includes an extensive use of the GAF as part of the training given on the SCID assessment.

After an initial appointment, patients underwent a personal interview where they were informed again about the scope and aim of the study. When the patient met all the requirements and agreed to participate, he/she signed the informed consent and the assessment was performed using a computer application software. Following the clinical interview, patients were asked to fill-in the self-reported questionnaires.

2.4. Instruments

We collected data on sociodemographic characteristics of the included patients. Additionally, the following instruments were included:

Mini-International Neuropsychiatric Interview 5.0 (MINI)

We used the Spanish version of the MINI 5.0 (Ferrando et al., 1998), an algorithmic, fully structured diagnostic interview for Axis I psychiatric disorders in DSM-IV (Sheehan et al., 1998). The MINI decision algorithm stops the exploration of DSM diagnostic criteria when DSM requirements for a positive case are met. Given that the main focus of our study was on major depressive disorder and generalized anxiety and that the assessments had a limited time window, we explored only the following comorbidities: dysthymic disorder, (hypo)manic episode and panic disorder. Thus, with the MINI we only assessed 5 disorders and any other possible comorbidity was excluded from the assessment.