



Research report

Quantifying point prevalence of major depressive episode using lifetime structured diagnostic interviews

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ABSTRACT

Background: Estimates of the prevalence of mental disorders are vital for policy and practice. The aim of the current study was to compare estimates of point (30-day) prevalence of major depressive episode (MDE) derived from a lifetime diagnostic interview with estimates derived from an interview exclusively focussing on the 30 days prior to interview.

Methods: Study design consisted of face-to-face survey interviews using two separate versions (lifetime and current) of the depression module of the World Mental Health Survey Initiative version of the Composite International Diagnostic Interview (WMH-CIDI). The setting was an outpatient tertiary referral centre for the treatment of anxiety and depressive disorders. One hundred and sixty four people were randomly allocated to receive either the lifetime or current version of the WMH-CIDI. Point prevalent cases derived from the lifetime interview were compared to point prevalent cases comprehensively assessed by the current interview.

Results: The risk of being diagnosed with current MDE having been interviewed with a lifetime interview was higher, but not significantly higher, than the risk of being diagnosed with current MDE having been interviewed with a current interview (RR = 1.29, 95% CI: 0.82–2.03). Derived and comprehensive point prevalent cases were similar with regard to a range of depression-related clinical characteristics.

Limitations: The size of the sample precluded the ability to determine the equivalence of prevalence estimates. The observed relationships may be different in general community samples.

Conclusions: Point prevalence of MDE derived from a lifetime diagnostic interview may be slightly higher than that derived from a comprehensive current interview. However, point prevalent cases, regardless of how they are derived, are similar with regard to depression-related clinical characteristics.

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Prevalence, defined as the amount of disease in a population at a given point in time, is a key concept in epidemiology. Accurate estimates of the prevalence of a disease are vital to understanding the nature and size of the health challenges posed by that disease in a given population. In the field of psychiatry, estimates of the population prevalence of mental disorders have contributed significantly to many important government policy plans and initiatives (Jenkins, 2001). The most widely cited example of this is the recognition, based on estimates of

prevalence and associated disability, that mental disorders contribute substantially to the global burden of disease (Murray and Lopez, 1996). Estimation of prevalence also helps delineate sub-samples of individuals meeting criteria for a given mental disorder, the characteristics of whom are often investigated in detail to address issues such as the extent of service utilisation and need for treatment for people with mental disorders; the geographic, demographic and social risk factors associated with mental disorders; and, coupled with longitudinal enquiry, the etiological determinants of mental disorders. Therefore, accuracy in the estimation of prevalence is a fundamental imperative.

Estimates of the prevalence of mental disorders in the general population are typically ascertained via household surveys using

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lay-administered structured diagnostic interviews such as the World Mental Health Survey Initiative version of the WHO Composite International Diagnostic Interview (WMH-CIDI; (Kessler and Ustun, 2004)) which is the base instrument for the largest collection of psychiatric epidemiological surveys in the world, the World Mental Health Survey Initiative. The WMH-CIDI is composed of a series of questions designed to assess each and every diagnostic criterion for a large number of mental disorders. It employs a lifetime timeframe in which the presence or absence of symptoms *at any time in the person's entire lifetime up to the time of interview* is ascertained. This yields estimates of the lifetime prevalence of disorder. While the validity of lifetime prevalence has been called into question (Andrews et al., 1999; Patten, 2003; Wells and Horwood, 2004) clinical reappraisal studies demonstrate good to excellent agreement between WMH-CIDI diagnoses and those obtained via a clinician-administered diagnostic interview (Haro et al., 2006; Kessler et al., 2005).

Validity issues aside, a further criticism levelled at structured diagnostic interviews that employ a lifetime timeframe is that lifetime prevalence is relatively uninformative when attempting to understand how a population is *currently* affected by mental disorders, information which is vital for effective health service delivery and treatment prioritisation. In this situation an estimate of point prevalence (typically defined for mental disorders as meeting criteria at any time in the 30 days prior to interview) is more highly desired as this provides an indication, albeit an imperfect indication, of current demand for treatment (Eaton et al., 1981; Mechanic, 2003). Traditionally, estimates of point prevalence have been derived from lifetime prevalence using answers to a single recency question such as, in the case of major depression, "When was the last time you had an episode of being sad, discouraged or uninterested... lasting two weeks or longer?". Diagnoses are considered current if the respondent meets all lifetime diagnostic criteria and reports that the last time they experienced an episode was in the 30 days prior to interview. However, obvious difficulties arise as this approach assumes that, rather than assesses whether, all diagnostic criteria are met within the critical 30-day period. Because of this it is possible that this "derived" point prevalence may not be an accurate representation of a "comprehensive" estimate of point prevalence (i.e. one derived from an interview that comprehensively enquires about each and every diagnostic criterion in the 30 days prior to interview). As has been shown previously systematic misclassification of cases can lead to problems in the epidemiological investigation of risk factor–disease relationships (Hofler, 2005).

To date little is known about the extent and impact of misclassification that could arise from deriving point prevalence estimates from a lifetime diagnostic interview. Therefore, the current study aims to quantify the difference between prevalence estimates of a common mental disorder, major depressive episode (MDE), derived from a lifetime interview and those derived from a current interview (i.e. one exclusively focussing on the critical 30-day period prior to interview). Point prevalence estimates are examined in the total sample as well as in important demographic sub-groups defined by sex and age. Point prevalent cases derived from the lifetime interview are then compared to those derived from the current interview with respect to important depression-related clinical characteristics such as functional impairment

as a result of the depression, emotional distress and depression severity.

1. Method

1.1. Study setting and participants

The study was carried out between April 2006 and January 2007 at the Clinical Research Unit for Anxiety and Depression, an outpatient unit for the assessment and treatment of anxiety and depressive disorders. The unit is a joint hospital and university teaching facility located in Sydney, Australia. Approximately 600 clients are assessed each year at the unit with treatment being offered to about 65% of people. Treatment is typically carried out in groups, adheres to a cognitive behavioural framework and has been shown to effectively aid in the recovery of clients both over the short and long term (Hunt and Andrews, 1998). Participants for the study were drawn from all clients presenting for their initial assessment. Four hundred and forty eight people were assessed during the study timeframe and 164 people actually participated in the study. This relatively low participation rate was not a result of refusal on the part of the potential participant. In fact a total of 171 people were approached to take part in the study. Two people (1.2% of the total sample approached) refused to participate, four people (2.3%) started but did not complete the diagnostic interview and one person (0.6%) completed the diagnostic interview but subsequently withdrew their data from the study. Instead the relatively low participation rate was due to the limited research personnel available to carry out the diagnostic interviews. An examination of demographic characteristics amongst those who did and those who did not participate in the study suggested that the only evident difference was in age with those who participated being, on average, four years younger than those who did not participate ($t=2.90, p<0.001$). There was no evidence of differences in other important demographics between groups (sex: $\chi^2_{(1)}=0.90, p=0.35$; marital status: $\chi^2=0.76, p=0.69$; education: $\chi^2=0.01, p=0.96$).

1.2. Diagnostic assessment of lifetime and point prevalence of major depressive episode

The instrument used to obtain estimates of lifetime and point prevalence of both DSM-IV and ICD-10 major depressive episode (MDE) was the World Mental Health Survey Initiative version of the Composite International Diagnostic Interview (WMH-CIDI; (Kessler and Ustun, 2004)). The WMH-CIDI is a fully structured lay-administered diagnostic interview which generates diagnoses according to the diagnostic criteria of DSM-IV and ICD-10. The validity of the WMH-CIDI has been assessed through clinical reappraisal studies in which WMH-CIDI diagnoses are compared to diagnoses made using the Structured Clinical Interview for DSM-IV (SCID) with generally good concordance found between the two interviews for the anxiety, mood and substance use disorders (Haro et al., 2006).

For the purposes of the current study the depression module was initially shortened by removing questions not directly contributing to the final diagnosis. These questions concerned non-diagnostic aspects of disorder such as consultations with health professionals, treatment history, and

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