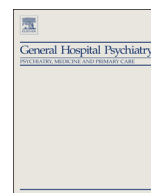




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journal homepage: <http://www.ghpjournal.com>Suicidal ideation in German primary care [☆]Jan F. Wiborg, Ph.D. ^{a,b,*}, Dorothee Gieseler ^a, Bernd Löwe, M.D., Ph.D. ^a^a Department of Psychosomatic Medicine and Psychotherapy, University Medical Center Hamburg-Eppendorf & Schön Clinics Hamburg-Eilbek, Germany^b Expert Centre for Chronic Fatigue, Radboud University Nijmegen Medical Centre, The Netherlands

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ABSTRACT

Objective: To examine suicidal ideation in a sample of German primary care patients.**Methods:** We conducted a cross-sectional study and included 1455 primary care patients who visited 1 of 41 general practitioners (GPs) working at 19 different sites. Suicidal ideation and psychopathology were assessed with the Patient Health Questionnaire (PHQ) in an anonymous screening together with health care utilization.**Results:** One hundred seventy-one (11.8%) of 1455 patients endorsed the suicidal ideation item of the PHQ. These patients were significantly younger, more often female and unmarried, suffered more often from psychopathology and reported more health care utilization than patients without suicidal ideation. Patients with the highest frequency of suicidal ideation also talked more often routinely about psychosocial problems with their GP, used more often medication against their complaints and searched more often for a psychotherapist than other suicidal ideators. Yet, these patients were not more likely to be in psychotherapy at the time of the screening.**Conclusion:** Our data suggest that suicidal ideation is a common phenomenon in primary care, which is independently associated with psychopathology in terms of depression, anxiety and somatoform complaints. Psychosocial support from GPs and medication seem to be easier available for primary care patients with suicidal ideation than psychotherapy, independent of the severity of the suicidal ideation.

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1. Introduction

Each year, approximately 1 million people commit suicide worldwide [1]. Highest incidence rates have been found in Eastern European countries with more than 30.0 suicides per 100,000 inhabitants [2]. Rates in Western European countries are usually lower. For example, Germany and Denmark both reported 11.9 suicides per 100,000 inhabitants, which is similar to the rates of Northern American countries [2]. Many suicide victims had contact with a general practitioner (GP) in a primary care setting in the weeks before the suicidal act [3]. GPs are therefore supposed to play a key role in the prevention of suicide [4–6]. Suicidal ideation functions as a red flag in this context to identify patients who are in need for additional support.

Studies suggest that up to 10% of the patients who visit general medical care suffer from current suicidal ideation [4,7,8]. Considerably higher rates were found in primary care patients with depression [9–12].

Additional psychopathology seems to further increase the likelihood of suicidal ideation in these patients [13]. Such insights are useful for the management of suicidal ideation in primary care, but most of the available data were gathered in the US and need to be replicated and extended by international studies. The purpose of the present study was to examine suicidal ideation in German primary care settings. We were interested in the number of patients who engage in suicidal ideation as well as their specific characteristics, including mental health status and health care utilization.

For this purpose, we analyzed the primary care data of a large regional study of the Hamburg metropolitan area designed to improve the health care situation for patients with mental health problems [14]. Assessment of mental health included screening for depression, anxiety and somatoform disorders, which represent the most common mental health problems in primary care settings [15,16]. Assessment of health care utilization included frequency and content of GP consultation, (the search for) psychotherapy and use of medication, which are central aspects of the management for patients with suicidal ideation [5,6,17,18].

2. Methods

2.1. Sample

Data were collected from 41 GPs at 19 different sites. All sites were located in the city of Hamburg (Northern Germany) with 1.8 million

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inhabitants. Most sites were within the reach of the University Medical Centre, which coordinated the study. The sites consisted of either one ($n=7$), two ($n=5$), three ($n=5$), four ($n=1$) or five ($n=1$) GPs. Typical patient flow per GP varied between 340 and 1200 consults per quarter of a year. GPs were visited on 2 to 4 days depending on the size of the site. On these days all patients were asked in a consecutive order to answer a short questionnaire about their health status and treatment situation. Patients provided oral informed consent for this anonymous screening. The study protocol was approved by the local ethics committee. Patients who were not able to fill in the screening questionnaire due to physical and psychiatric impairment or language problems and patients who were under the age of 18 years were excluded from the screening. One thousand six hundred forty-five (87%) of 1882 eligible patients accepted the screening questionnaire (see Fig. 1 for a flow chart of the study). One hundred ninety patients were excluded from the present study due to missing data. Median inclusion rate per site was 78 patients (range=34–127).

2.2. Instruments

The screening questionnaire consisted of three parts. A mental health section included three subscales of the Patient Health Questionnaire (PHQ): the PHQ-8 to assess depressive symptomatology, the generalized anxiety disorder (GAD)-7 to assess symptoms of anxiety and the PHQ-15 to assess somatoform complaints. A cutoff score of 15 (or higher) was used for all three subscales to indicate psychopathology [16,19]. This cutoff has good sensitivity while maximizing specificity for the identification of disorders in the corresponding area. Item 9 from the PHQ-9 was used to indicate suicidal ideation [7,9], asking whether patients have been bothered by thoughts of being better off dead or of hurting themselves over the last 2 weeks. Items of the PHQ that were left unanswered were interpreted as a score of zero [19]. A demographic section consisted of age, gender, marital status, education, nationality and health insurance status. In a final section about health care utilization, we asked the following questions: “how often have you been visiting your GP during the last 6 months?” “How often do you talk

about psychosocial problems with your GP?” “Have you been searching for a psychotherapist during the last year?” “Are you currently in psychotherapy?” “Do you take medication against depression, anxiety, or stress on a regular basis?” “Do you take medication against pain on a regular basis?” All response categories (with the exception of age) have been dichotomized to enhance interpretability of the results.

2.3. Statistical analysis

Rates of suicidal ideation and psychopathology were compared between patients who were excluded due to missing data and patients who were included in the present study. We also tested whether suicidal ideation rates differed significantly between the various GP sites of our study to examine whether the site should be included as factor in subsequent analyses. Next, differences between patients with suicidal ideation and without suicidal ideation were tested on demographic variables, psychopathology and health care utilization. We used univariate χ^2 tests for all of these analyses. We then conducted a forward multiple logistic regression analysis to identify variables that would best characterize patients with suicidal ideation in our sample of primary care patients. In a final analysis, we examined whether health care utilization might vary significantly based on the frequency of suicidal ideation using χ^2 tests. Statistical significance was set at $P \leq .05$ for all analyses.

3. Results

A comparison between those patients who were included into our study ($n=1455$) and those who were not included due to missing data ($n=190$) revealed that the group of excluded patients was not significantly more likely to suffer from suicidal ideation ($P=.277$) and psychopathology in terms of anxiety ($P=.501$) and somatoform complaints ($P=.686$). Yet, significantly ($P=.019$) more included patients had depressive psychopathology (6.3%) as compared with patients who were excluded due to missing data (2.1%).

In total, 11.8% ($n=171$) of our 1455 patients endorsed the suicidal ideation item of the PHQ-9. There was a considerable range of suicidal

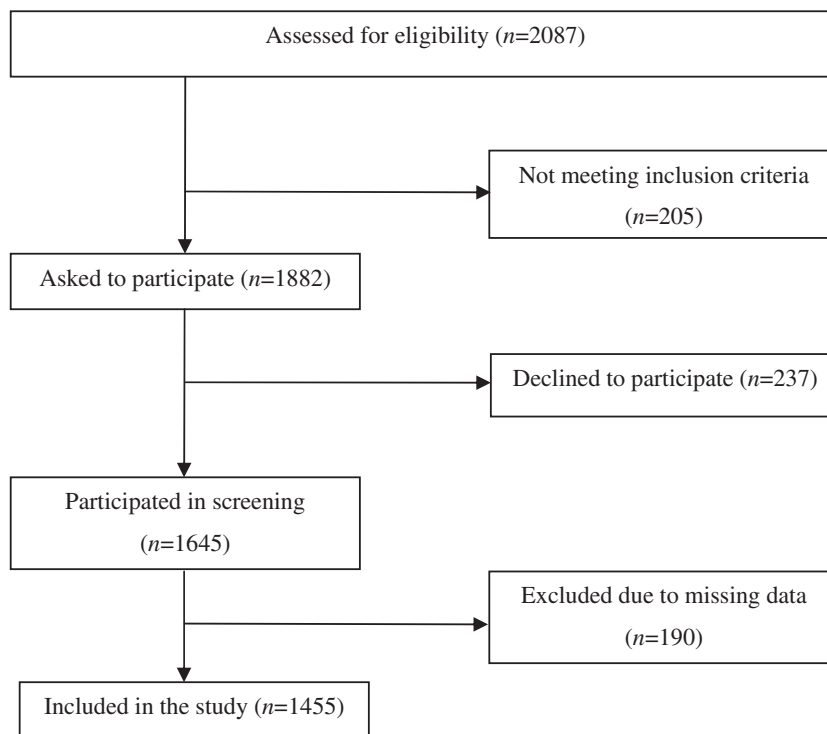


Fig. 1. Flow chart of the study.

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